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MEETING NOTICE

Marriage and Family Therapist Education Committee

March 9, 2007
Golden Gate University
536 Mission Street
San Francisco, CA 94105
(415) 442-7800

10:00 a.m. – 12:30 p.m.

- I. Introductions
- II. Review and Approval of July 21, 2006 Committee Meeting Minutes
- III. Review and Approval of October 27, 2006 Committee Meeting Minutes
- IV. Review and Approval of December 8, 2006 Committee Meeting Minutes
- V. Presentation by Marianne Baptista, MFT on Training in Recovery Models
- VI. Presentation by Rusty Selix of California Council of Community Mental Health Agencies
- VII. Discussion of Draft Revisions to Curriculum Statutes
- VIII. Future Meeting Dates
- IX. Suggestions for Future Agenda Items

Public Comment on items of discussion will be taken during each item. Time limitations will be determined by the Chairperson. Items will be considered in the order listed. Times are approximate and subject to change. Action may be taken on any item listed on the Agenda.

THIS AGENDA AS WELL AS BOARD MEETING MINUTES CAN BE FOUND ON THE BOARD OF BEHAVIORAL SCIENCES WEBSITE AT www.bbs.ca.gov

NOTICE: The meeting facilities are accessible to persons with disabilities. Please make requests for accommodations to the attention of Christina Kitamura at the Board of Behavioral Sciences, 1625 N. Market Boulevard, Suite S-200, Sacramento, CA 95834, or by phone at 916-574-7835, no later than one week prior to the meeting. If you have any questions please contact the Board at (916) 574-7830.

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Agenda Item II:

Review and Approval of July 21, 2006
Committee Meeting Minutes

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Meeting Minutes
Marriage and Family Therapist Education/Curriculum Committee
July 21, 2006

Hilton Burbank Airport Hotel and Convention Center
2500 Hollywood Way
Burbank, CA 91502

I. Introductions

The meeting was called to order at 9:35 a.m. Dr. Russ introduced committee members and staff present. Audience members introduced themselves.

Committee Members Present:

Dr. Ian Russ, Chair
Donna DiGiorgio
Karen Pines

Staff Present:

Paul Riches, Executive Officer
Mona Maggio, Assistant Executive Officer
Christy Berger, Legislation Analyst

II. Purpose of Committee

Dr. Russ explained that the MFT Education Committee (Committee) is tasked with reviewing the curriculum of California's marriage and family therapy education and determining its appropriateness for today's Marriage and Family Therapist (MFT) practice. The Committee hopes to come to a series of recommendations if needed, for what that curriculum should look like. That could range from doing nothing or making a lot of revisions, or anything in-between. The Board's goal is to ensure persons who are licensed are competent to practice without supervision, so the Committee will examine what MFTs are doing in California to determine whether the profession has evolved and whether the education has kept up with that evolution.

Dr. Russ acknowledged that part of the inspiration for this review is the enactment of Proposition 63, the Mental Health Services Act (MHSA). The MHSA is providing a greater opportunity for MFTs to work in public mental health agencies. The purpose of today's meeting is to get a sense of whether the Committee is heading in the right direction. For example, are we covering all of the bases, getting the right information, and talking to the right people. Dr. Russ expressed his hope that this will be a community project, that it will generate discussion at schools, consortium meetings and worksites that will be shared with the Committee.

III. Draft Environmental Scan

Dr. Russ explained that the Environmental Scan is a list of informational resources and key stakeholders in this process. He asked that the California Association of Marriage and Family Therapists (CAMFT) and the American Association of Marriage and Family Therapists (AAMFT) be added as information resources to the Environmental Scan; they can also be considered stakeholders but their role is more as an informational source.

Dr. Russ opened the floor and asked for input as to whether the environmental scan was complete. He asked the audience to contact him if additional ideas came up after the meeting.

An audience member asked whether we had considered taking input from mental health consumers.

Dr. Russ asked how this would occur. The member stated that we should identify key groups, categorize them, and seek out adequate sample sizes.

IV. Presentation on DACUM by Mr. Jose Luis Flores

Mr. Flores of Phillips Graduate Institute described several major sources of information about MFT practice and the competencies required for practice. Mr. Flores was involved in the development of one source entitled “Developing a Curriculum” (DACUM). Another source is the MFT occupational analysis, which is the basis for the MFT licensing examinations. Another source of information is CAMFT’s demographic survey of its members.

Mr. Flores explained that DACUM is a process used to gain a sense of what individuals are doing within a profession. This process was used by the California Mental Health Planning Council (CMHPC) to both identify what MFTs are doing in the field and what MFTs are doing in public mental health (county and state systems). The CMHPC has identified a need for more mental health professionals including MFTs. If we need to develop a workforce in mental health and recruit MFTs, they need to be prepared to work in public service. The DACUM helps us to understand how to prepare MFTs for a career in public mental health.

Mr. Flores explained that the MFT DACUM panel was made up of individuals throughout the state from various public settings with different types of jobs within those settings. The group was led by a DACUM facilitator for two days, and was asked to identify tasks performed in MFT practice, how they completed those tasks, and the knowledge and skills needed to complete those tasks. This included tasks performed by MFTs in public mental health at different levels. The group brainstormed about the future of MFT practice and mental health services.

Mary Riemersma, Executive Director of CAMFT, stated that the one thing not identified in the DACUM is what is not being taught adequately to MFTs. She feels that this is probably the next step. We also need to identify where can or where should this information be infused into programs, or whether it should be taught outside of school as part of on-the-job training.

Dr. Russ stated that a lot of MFT training takes place during the internship, where a person learns skills in specific areas. Dr. Russ had spoken with Ms. Riemersma about a certificate type of program. It is ironic that 48 units are required of MFT programs but to go into public service for what feels like a lot less money, a person would potentially need additional units.

Ms. Riemersma responded that there is a cadre of pre-licensed individuals who do not want to go into private practice. A good place to develop skills is to work in public mental health, and then one can later transition into private practice. In CAMFT surveys, she is seeing that where this was once truly a private practice profession, it is not anymore. Consequently we should be preparing students for both types of practice. One of the problems is that the schools are feeling very stretched trying to get everything that they want to teach in 48 units, and some schools require more units which require more money. Another factor is educators who are not trained to prepare students for public mental health. Ms. Riemersma applauds the board for looking at this issue because it is necessary now to chart the course.

Mr. Flores explained that many of the DACUM panel members learned these duties during on-the job training. Much of what came out of the DACUM is clinical practice and is already taught in the programs. The schools are being encouraged by the consortium to look at the DACUM and determine areas that are not being taught.

Olivia Loewy, Executive Director of the AAMFT California Division, commented that theoretically, a license holder is competent to work without supervision to treat anyone who walks in the door. But do we want to say that people must go beyond that to obtain a special certificate in order to work in a public setting in which there are layers of supervision and where the pay is less? Are we creating a disincentive for people to work in the public sector and undermining our ability to increase that

workforce? One of the things the DACUM made very clear is that there are MFTs doing exactly the same work as social workers, and are being taught on the job just like social workers. Why are MFTs subjected to a DACUM process and not Licensed Clinical Social Workers (LCSW)? Isn't it the responsibility of the board to ensure that MFTs who are licensed are prepared to work within the broad scope of the mental health services they provide?

Mr. Riches explained that the Deans of Social Work went through a similar process to identify competencies about what is needed to go into public mental health, so there is a parallel process for social workers.

Ms. Riemersma stated that we need to look at DACUM differently. It is a very positive thing that gives us a good background for how to prepare MFTs for the future. Social workers have traditionally worked in public settings. MFT were historically trained for private practice, and have some obstacles to overcome. A lot of the training will happen on the job, but we need to provide a foundation and some grounding about the differences between private practice and the public sector. We need educators that can convey that information to the students.

A member of the audience commented that community mental health is populated with persons of color, so MFTs are going to serve those communities and students need to be trained as such. Students come in knowing this, and there is a shift in that many new MFT students are people of color. It is critical to understand the types of students coming in when we shape the curriculum, and many are already serving the community but want to go back with a professional degree.

Dr. Russ asked how much of the training could be handled in the free market economy of schools. For example, if someone wants to focus in public mental health they could attend a school that offers a specialized degree.

Mr. Riches stated that we must always be mindful of the market, which is one of the most powerful forces out there, but one of the things that government does is set the parameters of the market. A core piece of the evaluation is how do government rules shape or unbalance that market. There is a lot of data gathering we need to do, and we need to ask whether there are statutory forces that skew the market.

Ms. Pines stated that she believes the MFT DACUM must be a part of the upcoming MFT occupational analysis. It needs to be reflected in the examinations. What we do beyond that, what schools want to provide to students to make them market-ready is beyond that.

Mr. Riches shared that staff met with the Office of Examination Resources (OER) yesterday for an initial discussion about the upcoming MFT occupational analysis, which performed every five years. The MFT DACUM will be provided to OER to ensure they reflect this as well as information from the curriculum committee meetings in the analysis.

Mr. Koutsolioutsos of Pacific Oaks College stated that the MFT profession is now doing everything in mental health including directing programs. He explained that the 48 units includes all courses the board has mandated, but other courses the board has mandated have not been integrated into the curriculum because it would go beyond 48 units. We need to determine whether 48 units are adequate. From an educational point of view, we have to teach a little bit of everything, and we are giving very few units to many critical pieces of learning. For example within one class, 20 theories have to be taught. How will a student become an expert in one theory when they aren't given the opportunity to study any one in depth?

Mr. Koutsolioutsos stated that there are three key areas in the DACUM that are not covered in the current MFT curriculum: case management, administration, and education. Considering that we are already giving three units to psychopathology, for example, why not just give two to three units for each

one of these categories? You can do a three-class certification program and incorporate these new areas very nicely.

Mr. Flores stated that the Committee needs to be careful when looking at the DACUM, which reflects licensed practice. Schools cannot teach all of the tasks in the DACUM, and much will be covered post-graduation during supervised experience. Schools can teach some of this, but clinical training needs to be focused on some of these areas.

Ms. Pines stated that the Committee should keep in mind that there will be an elective element to this. We shouldn't put everything in the curriculum because not everybody intends to go into public practice.

Ms. Loewy asked that we look at the DACUM for the tasks that define minimum competency for licensure. She believes that the DACUM is a great springboard to use in the development of the occupational analysis, but not every new licensee or new graduate needs to be able to perform every task in the DACUM, there is so much learned on the job.

Ms. Wang of Alliant International University stated that she believes MFTs have to ask what is their social responsibility as a profession, as the majority of consumers come through public settings. Nationwide, more MFTs are in public practice, and less in private practice. So are we going to keep our curriculum for private practice only and if we do, what kind of message does that send? There are some agencies that refuse to hire MFTs if they have a choice because they feel MFTs are not trained. This limits consumer access to MFT services.

Mr. Riches stated that we need the clinical educators to help the Committee determine the foundational educational pieces that make a person ready for the skills to be gained in supervised practice. He believes we are in agreement that some tasks must be taught in school and some in training, but educators are in the best position to help us determine where those boundaries are and to make sense of all of the information.

Ms. Pines stated that as more MFTs become employed in public agencies, there will need to be a change in education to have some balance between private and public practice, but in the meantime we have to start small. There is some irony in that we are perhaps suggesting a certificate that takes time when some of the smaller agencies are recruiting bachelor's level graduates and they train them completely.

An audience member who teaches in a public university stated that change in an educational program can take two years to implement. Some things can be and may be better taught when incorporated within existing courses, but larger changes may require a certificate program. There also may be a problem with finding instructors who have the expertise.

Mr. Koutsolioutsos explained that he was a part of a committee of the MFT educator's consortium that looked at competencies. They determined that an MFT who doesn't have case management skills or the ability to provide education is providing less than adequate care.

Ms. Riemersma said she likes the concept of training that would provide case management and skills to work in the public sector, but for it to be meaningful it should be integrated and infused across each program similar to cultural skills. MFTs employed in public sector can have difficulty on the job because they don't have case management or recordkeeping skills. It is also a mindset that one is taught early on. For example, confidentiality requirements are completely different in an agency setting than in private practice. MFTs often don't understand that it is the agency as opposed to the individual providing the treatment. Many MFTs begin in a public agency then go to private practice, and a number will return to public practice.

An audience member from Antioch University stated that everyone's comments are interesting because Antioch is finding ways that begin to cover many of these issues, such as commonly used forms for the

Department of Mental Health. One of the criteria for their student placements is that the agency provide in-service training in areas such as case management. Antioch's mission is a social justice mission, so students are told about both private and public practice.

Ms. Wang stated that students have a big deficit, as they don't know the system of care, levels of care or where they fit in. She believes a specific class is needed to teach the system of care, the continuum of care, at what level care is needed, how the system of care is funded, and how it relates to other levels of care. We already give students a repertoire of skills, but they don't know where to plug this into the system.

Carla Cross from Loyola Marymount explained that Loyola has a similar approach to Antioch. Their mission is about service, and the program is structured around this. She believes we need to clarify the function of the school and the function of the practicum. The school's job is to teach concepts, fundamentals, good practice, theory, the conceptual ideas. Case management is something you learn in your placement, in supervision. A specific course is not needed for this narrow area. We are missing the value of the curriculum versus the practicum experience. We may need to have higher expectations of the practicum sites.

Mr. Flores explained that the panel members who contributed to the DACUM do not perform all of the duties listed in the report, not everyone who works in public practice does all of the tasks listed in the DACUM. He feels that it is important to keep that perspective.

Dr. Russ encouraged dialogue after today's meeting. Anyone can contact him with more information, comments, questions, and suggestions. The board wants agencies to be included in this discussion and will find a means to get them involved.

V. Review of MFT Occupational Analysis

Dr. Russ and Mr. Riches gave an overview of the MFT occupational analysis. The MFT examination outline is derived from the occupational analysis and MFTs are recruited to help formulate the examination questions. The examination outline, including content proportions, is available on the Board's website. Mr. Riches explained that the board will soon begin a new MFT occupational analysis. This process includes the OER interviewing a broad range of MFTs in different practice settings and with different types of experience. The information derived from the interviews goes to another group of MFTs who help to formulate the survey. When the survey is mailed, we will work to obtain a good sampling of different levels of practice and time licensed to provide the board with as accurate of picture as possible of current MFT practice.

Mr. Riches recently discussed with the OER about how to integrate MHSA principles and the move toward more public oriented practice into the occupational analysis. This is a key moment for us to get this information into the examination. However, the examination has to be job-related, not job-aspirational, so there are some boundaries.

Dr. Russ gave an overview about how the occupational analysis is used in the examination development process and that the current occupational analysis is available for our consideration. It represents what MFTs need to know for today's practice.

Mr. Koutsolioutsos suggested the Board wait one more year to conduct the occupational analysis to reflect the changes taking effect with the MHSA, including the funds available from MHSA in terms of training, and accounting for the number of individuals that will be working in public mental health. This would help us determine how much the curriculum needs to change.

Mr. Riches explained that this committee's work will take a long time, and we will need the results of the new MFT occupational analysis before determining the recommendations, as it is the bedrock of the curriculum review in a lot of ways.

Ms. Stephanie Thall stated that some schools may not have a public mental health track. At the schools where she teaches she would be surprised if students or even some instructors know what the MHSA is. She believes it has to start with instructors knowing about the MHSA, and that it is important to bring in consumers into the classroom to share their experiences.

Ms. Cross stated that whatever the outcome of this committee's work, what is most important to her as an educator is participating in the dialogue, sharing approaches, experiences, and philosophies. It is not just the content but who we are and what we teach.

An audience member stated that many students look at public practice as a "tour of duty" and that they will "retire" to private practice. It still seems to be a struggle to get across that public service could be a career choice.

Mr. Riches stated that having one career is an antiquated notion. Statistically, most people in the younger generations will have three to four different careers because our work span is now 40 to 50 years. It is an obligation to inform students that they will likely have several different careers and to be prepared for those different careers.

Ms. Wang stated that the profession is facing major changes. A hidden fear is how these changes will impact the license. An audience member stated her belief that it is not just a fear, it is more a lack of clarity. One example is the differences in the scope of practice for MFTs versus LCSWs. As MFTs move toward doing more things like case management, what does that mean for the MFT scope of practice?

Dr. Russ explained that the history of the development of the different mental health licenses is very different but once a person obtains the license no matter the education and experience, each license wants the ability to work in all types of mental health settings.

Ms. Riemersma stated that in terms of the MFT and LCSW scopes of practice, they are very broad and only limited by one's own scope of competence. While MFTs come from a different perspective than LCSWs, their scope of practice gives them a broad ability to provide services.

Mr. Riches stated that the MFT profession has a bit of a struggle with professional identity. There is a recognition that the practice setting is changing, but what does this mean for the profession? Even different programs have a different conception of what that identity is. As a government agency we may have some influence on that discussion but ultimately that is a possession of the profession.

Ms. Loewy believes it would give students a sense of what they can contribute by having the schools impart what is unique to MFTs, and what MFTs have to contribute within the larger scope of the services being provided.

Ms. DiGiorgio asked whether there was information for consumers about the distinctions between the mental health professionals. As a consumer, she wouldn't know which professional would be best for a given problem.

Ms. Riemersma explained that any mental health professional is theoretically qualified to help for any problem, but their approaches are different.

An audience member asked why this scrutiny is being applied to MFTs if they can do everything and why not to LCSWs? If there is so much overlap in professions why are we here? MFTs are being asked how they are competent to work in public arena, but are LCSWs being asked if they are competent to work in private practice?

Dr. Russ responded that there are two reasons for the review. The MHSA is a driving factor in that various departments are saying if MFTs want to work here they have to have that bridge. Additionally, the MFT curriculum is determined by the state, but the LCSW curriculum is not.

Mr. Riches explained that a license is general and you don't want to confuse a person's capabilities in a setting with the scope of practice. The BBS has a public protection mandate and we have to make sure the licensing standards we have in place protect the public. Mr. Riches emphasized that he is not saying that MFTs are not qualified. The question is whether the state laws reflect the future MFT practice reality.

Mr. Koutsolioutsos stated that the general premise of this work seems to be to identify the scope of practice and decide what competencies are required for this wide scope of practice. The committee should look at what is good practice, which is very different from scope of practice. MFTs need to bring in some social work components in order to meet the needs of consumers.

VI. Future meeting dates

Dr. Russ asked for advice on how to get the rest of the stakeholders identified in the meeting package to contribute to this process. Mr. Flores stated that the MFT consortia may be able to help in bringing in supervisors, and there are regional associations of mental health agencies that we could tap.

Dr. Russ asked if people have ideas to let him know, and encouraged the professional associations to invite comment through their publications.

Mr. Riches announced the next meeting date and tentative months being considered for future dates. The first date is Friday, October 27, 2006 in Northern California, probably in the Bay area. There will also be a date in December 2006 and a date in March 2007. We will discuss substantively different content at each meeting as identified on the Environmental Scan and will target certain meetings to different stakeholders.

Dr. Russ stated that other information sources will be asked to give presentations at future meetings so that we can come up with a good decision.

Ms. Wang asked whether future meetings can include teleconferencing. Mr. Riches stated that we will check into it but it presents particular challenges due to the public meetings act. We will do our best to keep everybody in the loop. Mr. Koutsolioutsos suggested that the board survey students in clinical training classes. Another audience member suggested also surveying faculty.

Mr. Flores asked about the time frame to give the Committee's findings and recommendation to the Board. Mr. Riches stated that this process will be a minimum of four to five committee meetings just to look at the data outlined in the Environmental Scan. The recommendations should be ready by late 2007.

Ms. Wang suggested the board send a questionnaire to agencies that receive MHSA funding, asking about their needs. Mr. Riches responded that the MHSA currently has a needs assessment process being conducted, and we will take a look at that as well as other data sources.

VII. Suggestions for Future Agenda Items

None were received.

The meeting was adjourned at 12:00 p.m.

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Agenda Item III:

Review and Approval of
October 27, 2006
Committee Meeting Minutes

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**BOARD OF BEHAVIORAL SCIENCES**

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Meeting Minutes
Marriage and Family Therapist Education/Curriculum Committee
October 27, 2006

Crowne Plaza Hotel SFO
1177 Airport Blvd
Burlingame CA 94010

I. Introductions

The meeting was called to order at 10:03 a.m. Dr. Russ encouraged discussion from the audience, and encouraged the audience members to spread the word about the Committee. Audience members, staff, and committee members introduced themselves.

Committee Members Present:

Dr. Ian Russ, Chair
Donna DiGiorgio
Karen Pines

Staff Present:

Paul Riches, Executive Officer
Mona Maggio, Assistant Executive Officer
Christy Berger, Legislation Analyst
Justin Sotelo, Regulation Analyst

II. Gap Analysis of Curriculum Standards (BBS Occupational Analysis, DACUM Competencies, AAMFT Core Competencies for MFTs, AMFTRB Practice Analysis)

Dr. Russ mentioned that our task is to set the minimum qualifications for the MFT curriculum. He explained that Christy Berger prepared an analysis and comparison of a number of studies of MFT practice to current educational law.

Ms. Berger started with a disclaimer, that she is not a clinician, so her interpretations in the analysis may be somewhat lacking. Additionally, the comparison was fairly difficult because MFT education law contains items that are very general and some that are very specific. She explained that the proposed language is just a first draft and that the Board is very open to feedback.

The results of the analysis showed that MFT education law is lacking in public or community practice. She mentioned that the Board's statutory language may need refinement as there seem to be overlapping requirements. The studies used for comparison in the analysis and the results were as follows:

The BBS MFT Occupational Analysis (OA), which matches up well with the Board's MFT education law. This may be due to the fact that many of the respondents to the OA were in private practice and the MFT educational requirements were likely designed for private practice.

The AAMFT Core competencies also matched up well with MFT education law, except that it does not include any of the competencies defined in AAMFT's Research and Program Evaluation domain. Dr. Russ had pointed out that some of these competencies seem to be aspirational, and not required for minimum competency.

The MFT DACUM had the greatest number of tasks that did not fit into current MFT education law. This was a difficult comparison because of the way the DACUM was written, in very brief, focused task statements. Of the tasks that did not fit, most were administrative and not directly relevant to clinical practice. Those that are relevant are where administration and clinical skills come together such as report writing.

The AMFTRB Role Delineation Study matched up well with MFT educational law.

Mary Riemersma, Executive Director of the California Association of Marriage and Family Therapists (CAMFT) asked a question about the occupational analysis. She asked whether the right questions were asked to elicit the responses that might have demonstrated there is more training happening in the public sector than have been identified?

Ms. Berger explained that the task and knowledge statements are developed by practitioners from a range of practice settings. She indicated that the majority of respondents to the OA were in private practice, but Ms. Berger did not have the statistics at hand regarding the number of respondents from public practice settings.

Mr. Riches explained that in developing the OA questionnaire, the prior questionnaire is used as a point of reference, and this is done through a focus group process to make changes to it, sometimes they are dramatic, sometimes more incremental.

Ms. Riemersma responded that if you're modifying a prior instrument, you may not be giving thought to different types of competencies, you might leave out a component.

Mr. Riches explained that we know the demographics of those who responded to the survey, but because of how the survey questions are rated, there may be items that did not make the critical index cutoff, which determines the final set of task and knowledge statements. If you have a smaller sample in one area, that could be impacted. He stated that he would be addressing the focus groups regarding the changing practice environment. The specialist that is running the workshops has been briefed on the emerging issues with public practice and has been given a copy of the MFT DACUM.

Dr. Russ asked Ms. Riemersma whether she felt that something was missing in the OA. She responded that probably community and public sector environment is fairly silent, and she wonders whether this is because it's not a large part of the profession, or is it because the right questions have not been asked.

Vonza Thompson, MFT and CEO of Alliance for Community Care, explained that public employers often have to adjust the job duties of a position to match what individuals have been trained to do. So if the Board is only surveying individuals in practice, they are not getting the perspective of the practice settings. The Board may not be getting the full picture. The Mental Health Services Act (MHSA) is supposed to transform the system, so employers have to get current employees up to speed, and if new workers can have a

better understanding of what they're going into, they can get a match that's much better than what they're getting now.

Ms. Pines described her years of agency and nonprofit work and her experiences with new MFT employees who often want to learn how to do this type of work. However, she stated that some have no interest. She believes we should make the public practice component voluntary, and not send everyone through the same training when many have no intention of practicing in a public setting.

Dr. Russ asked the public to look at the MHSA training components and what you know to be the reality and tell the committee what elements are missing from MFT requirements. If MFTs are going to be in this workforce, then we need to begin thinking now what those minimum qualifications should be.

A member of the audience stated that some of the directions that the public system is hoping to go also applies to a private practice therapist. One example would be the use of practices backed up by data. Except on the administrative side, it shouldn't be so different for those in private and public practice, except that the public sector tends to work with the more severely disabled.

Mr. Riches asked the audience, what are the three top things that job applicants are lacking. A director of an agency responded that one would be lack of knowledge regarding charting and generic responses regarding selection of interventions for particular clients. Dr. Russ asked whether it was different for interns as opposed to licensees. She stated that it was a problem for both.

An educator in the audience, who is also a member of the Bay Area Mental Health Directors Education and Workforce Collaborative, stated that one challenge of the MHSA is the aspiration toward different structural relationships between the preparation of professionals and the employment of those attracted to working in the public sector. This is beyond content knowledge and skills. He hopes this committee will discuss those needs. He suggested we work with the Collaborative to get a sense of what the missing elements are in the preparation of new employees. Dr. Russ offered to come to a meeting of the Collaborative and bring that information back to the Committee. This person explained he is also a member of the Northern California MFT Educator's Consortium, who have been discussing creating a certificate for MFT public practice, which he hopes will be discussed here. Dr. Russ offered to attend one of their meetings as well.

Ms. Pines mentioned her belief that a certificate is a good way to go because it also provides the opportunity for existing licensees to go into this field.

Olivia Loewy, Executive Director of the American Association of Marital and Family Therapy, California Division (AAMFT-CA) expressed her opposition to the idea of a certificate, due to concerns that this would establish a tiered system. They are concerned that this would discourage professionals from participating in public practice. She encouraged the Board to ensure that anyone licensed will be qualified to work in any setting, rather than the use of a specialty certificate. She believes there needs to be a review of the curriculum, but not extensive. She wondered whether a certificate would actually make a difference to an employer.

Ms. Thompson stated that requiring a separate certificate could have a negative impact on workforce shortages and strikes her as unusual as an employer. She agrees that the system needs to be tinkered with, but does not feel there should be two tracks.

Ms. Riemersma stated that in time, public sector work needs to be interwoven in each class. For example, a law and ethics course would include public and private sector distinctions, and mental health educators need an understanding of the public sector to be able to teach that, and they are not there yet. Because of this, students have somewhat of a culture shock when they go to work in a public setting. Many things will have to be learned on the job, but they should get enough exposure so that they are comfortable with it. Regarding the certificate, it is not intended as a condition to be employed or something the Board would be offering. This is would come out of the private sector and educational institutions collectively determining the necessary education and training to qualify for a certificate to demonstrate that a person has gone over and above the requirements. The employer can hire whomever they want. This is a totally voluntary stopgap measure to fill in until the schools can assimilate changes to their programs.

Mr. Riches stated that we originally wanted to identify the foundational components that schools need to provide so that when they graduate, people have the tools so that they can learn to do the work. Not everything has to happen in the classroom, a lot is learned during the trainee and internship.

A member of the audience stated her support for the curriculum enhancement, stating that the law is outdated and it needs to be determined what is the best preparation for both private practice and community practice, basically good practice in different venues. She stated her support for the idea of a certificate as an option. She asked whether there been thought given more broadly than foundational, such as intern-level additional preparation. There is a lack of conceptual framing about what might be learned better at the intern level.

Dr. Russ asked whether a 48-unit program provides enough education, and if it doesn't what are the real world implications of expanding that?

An educator in the audience stated that their accredited program cannot add units as it is currently at 60, and there are other accrediting bodies they have to be accountable to. In two years, a program cannot address all areas of practice for MFTs. She is in support of a certificate, as many of their MFT students take training to equip them to work in school settings, for example. A certificate would target students who want to go the extra mile. Shouldn't burden all students and programs to add more required units.

Dave Schroeder, a partner (consumer) with Mental Health Associates and the County of Sacramento, stated that he comes from a different viewpoint, that of "what do my fellow consumers need." There is so much expected out of a person working in a public mental health system, why can't there be concentrated training for specialized areas of practice such as with physicians? The MHSA says that the needs of consumers are supposed to drive the system. The partnership is growing between the professionals and those using services. In his view, it shouldn't matter if you're in private or public sector, all persons should have skills to provide services to everybody. Additionally, he acknowledged that the consumer's desire for services are changing rapidly.

Dr. Russ asked Mr. Schroeder to invite other consumers to come to the Board's meetings. He stated that the medicine model is a good model, but the state model, which is the same as ours, licenses people as a general practitioner. Then, the American Medical Association offers certifications in specialty areas of practice. Psychologists have a similar model. The piece we are talking about right now is the minimum competency for the general practitioner.

An educator in the audience explained that educators have to move in the direction of evidence-driven practices to keep up with changing standards. We should be doing that here as well, we should develop some evidence to guide what we are doing, to understand what those different skill sets are for public practice that are different than private practice that need to be taught. This educator is concerned that a certificate may be detrimental to workforce shortage problems, as employers may begin to require the certificate.

Dr. Russ responded that we do have a lot of data, including an analysis of the workforce, MHSA mandates, as well as the AAMFT and DACUM studies. Dr. Russ invited the audience to contribute studies or other data that they feel may be missing. The educator stated that he agrees with Dr. Russ, and explained that it is more of a concern that we don't know what its going to take to teach these things, how many units or hours, that is the piece that is unclear in terms of data and evidence.

Mr. Riches explained that the Board mandates the major domains of knowledge that need to be addressed, but it is up to the schools to determine the best way to put it into practice. That flexibility is core because as evidence changes, as an educator have to reevaluate programs as the field changes. The Board doesn't want to mandate down to that level.

Duncan Wigg, an educator from Pepperdine University stated his appreciation of Mr. Riches' comments regarding minimum requirements of education as opposed to something expansive. He cautioned that specializations may not be the purview of the Board. It is the charge of the Board to prepare MFTs who are capable as independent practitioners to respond to anybody who walks into their office whether a private or public setting. That spirit is embedded in law already, and needs to be reemphasized. Also need to respond to multicultural needs to Californians, a charge Pepperdine takes very seriously, as they are working to infuse into every aspect of the curriculum. This may be a model for public practice. We have money coming our way and how do we quickly address a work shortage situation. The idea of a certificate is a good effort.

Dr. Russ encouraged groups to work on specialty certificates, and reemphasized that the Board's task is different. The Board is part of this because we know that MFTs are in an area of practice that is changing, and we have the obligation to look at minimum requirements to guarantee that when you get your license, the public is at least safe.

Mr. Riches explained that we have been hearing the same comments from employers for a long time, a sense that MFT preparation was not well-suited to public practice. We are trying to be responsive to that, and taking a look, not presuming one way or another. Also, there is new public policy in California – the MHSA says we must do things differently. Our licensing requirements are aligned with public policy. We have a statutory list of domains, educators have a dynamic environment, and we have sympathy for that.

An educator in the audience stated that changing policy with MHSA is really making schools look at what they are doing and incorporate some of the new model into

programs. There is a time lag before students will be coming out of programs with this new knowledge. It works much better is to infuse training into all aspects of program. For example, one class in multi-cultural training is not sufficient; people can't incorporate those issues into practice. This educator encouraged the Board to identify competencies that we would test in an exam but not mandate that schools add units. This gives schools the ability to infuse into curriculum what students need to be basically competent, but doesn't put a burden of hours and units.

Ms. Loewy endorsed embedding requirements within existing coursework. In community mental health treatment really differs from agency to agency, so even if a student has a specialization, they will still need additional training. Agencies don't expect someone who is ready to just come into their agency and do the work. Also, the MHSA is still in developmental stages as a system being transformed, and agencies will need to train in accordance with the MHSA.

An educator in the audience stated that part of the discussion is student competencies, but also what is the role of the Board. Are there emerging issues with the MHSA that the Board would want to alert, support, and remind the schools, ask whether they are developing this, and how are you going to do it.

Mr. Riches responded that yes, we are doing this for a lot of reasons, but we have a clear statement of public policy, the MHSA tells us to do things, and one thing the Board can do is support change by asking questions, etc.

Dr. Russ encouraged more school participation, as he would like this to be a community discussion.

III. Discussion Regarding MHSA Workforce Draft Strategic Plan and the Integration of MHSA Principles in Marriage and Family Therapist (MFT) Education

- 1. What do schools and agencies do currently to train students to be Culturally Competent?**
- 2. Do schools and agencies use consumers to train students as to the experience of mental illness and to the experience of obtaining treatment?**
- 3. Are schools teaching the MHSA recovery model? What does this mean when someone has a chronic mental illness?**

Dr. Russ presented the three specific questions that are being explored under this agenda item.

Ms. Thompson stated that she and her fellow CEOs believe that the basics of the MHSA need to be infused into their agency. Right now it should be the recovery model as there are many people who are very disabled with tough life experiences because of our current system. The consumer directed piece is very important, so anything we can do to encourage the schools and agencies to work together with consumers and families to see the change in philosophy would be great. Almost every part of training and assessment should shift, this is in attitude, beliefs, and the way we treat each other. The Board can't legislate a lot of that. She asked, other than the Board, who can play a role in getting some of these parts together?

Dr. Russ stated that schools and agencies are working together in consortia, which is essential.

An educator in the audience stated that the Bay Area Workforce Collaborative does that very thing, and that model is being replicated. The MHSA is very actively supporting this kind of communication and also funding it.

Bill Bruff from Saybrook University stated that the MHSA is a call to how do we have a single conversation about these kinds of issues. One of the challenges is not just to get consumers in, but to also create a climate in which consumers can be “out of the closet.” His school has students and faculty who are consumers or have recently been. There is not universal agreement about consumers and what consumer participation means, but we have to do it in partnership with those stakeholders. The recovery model is also being defined. For example, there are psychodynamic models that are antithetical to what some people hold as basic tenets of the recovery model. This can’t be solved by adding laws, but the challenge is how to have meaningful discussion that arrives at a workable effort.

Mr. Riches responded that he believes all of these things need to happen. The Board has a role, we are not going to solve a lot of these problems, but the role is how do we align what we do with these policy changes. It would be naïve to say, we’re not going to do anything in response to something that is transforming the system. The state through the Board has an obligation to make sure our licensing standards meet the needs of the public, some will be proscriptive, some not. A lot of work has to be done on a lot of levels to support this level of change. The collaborative is a great model. We will ask for accountability that you include certain content in your program, but we will not tell you how do you do it.

In response to the agenda questions:

Ben Caldwell, an educator from Alliant University stated in response to question one, cultural competency is infused throughout their curriculum, and has been an active area of focus for a long time; in response to question two regarding consumer participation, our school is deficient in this area. In response to question three, this is a difficult question to answer given the lack of specificity regarding the recovery model. As best as I understand it, we teach parts of it, including the psychosocial recovery model and good documentation.

Mr. Wigg stated in response to question one, cultural competency, including diversity in terms of age and socioeconomic status in addition to other things, is a high priority. They are constantly working to infuse this into the program; in response to question two, Pepperdine has three training clinics, all of which are geared towards clients of lower socio-economic status. However, only a minority of their students get exposure to these clinics. In response to question three, there is an emphasis of the recovery model being defined in contrast to the medical model. There are models of psychotherapy that are more strengths-based which are taught.

Linda Terry, an educator from San Diego State University stated in response to question one, they look for applicants who share the goals of their program, not those wanting to enter private practice. Theirs is a multi-cultural social justice program with an infusion and inclusion approach to diversity, which includes a sequence of three courses

focusing on cultural identity development as well as infusion into other courses. They have 75% students of color, and about 10% with a same-sex orientation. Their training program sees about 75% clients of color with about 30% who are non-English speaking. In response to question two, they do have forums in which a variety of consumer experiences are discussed, but it isn't what she would call a full ongoing dialogue. In response to question three, she concurred with previously stated responses.

An educator in the audience stated that most of the programs including theirs have become sophisticated about integrating multicultural competency into the curriculum. The next step is the faculty who is becoming much more multicultural as well as their student body, more dramatically recently. Regarding consumer involvement, they haven't really grappled with that issue yet and it will take some time before they have this infused into their curriculum. Students are out in the field, but are seeing it from the perspective of a provider, they are not seeing it as a joint venture.

Mr. Bruff stated responses similar to the previous responses and in addition, his school consciously recruits diverse faculty and students, teach a stand-alone diversity course, and also embed cultural diversity in all of the practicum. For the last two years they have worked to address issues of stigma, but have a long way to go. They have had presenters such as CASRA present on their model of consumer participation as well as others, so these are some pilot efforts, but there is a long way to go for full consumer participation.

Mr. Schroeder explained that consumers, especially those from different cultures did not have choices in the past, as far as types of services available. The definition of recovery changes with every individual, and may change on a daily basis for every individual. It is less a definition than a concept. The underlying thing is what does a person need in order to recover. For many years, their choices were mandated, not chosen. They want to be partners. He also expressed his dislike for the word "consumer," and prefers "partner."

Dr. Jennifer Frei from the University of Phoenix stated responses similar to others and stated that they have a specific diversity class, but this is also embedded in other classes. Consumer participation is a short-coming at this point. She explained that they do address the psychosocial model, but they have a way to go regarding the recovery model.

Mr. Riches asked whether the institutions are thinking about existing faculty and how to get them up to speed.

Lesley Zwillinger, an educator from San Francisco State University, stated that they are doing that and are also talking with the DMH about some MHSA education and training funding for training of faculty.

Mr. Wigg stated that Pepperdine just had its first multicultural lab that included faculty, students and alumni who interacted and discussed how both instructors and students can become more culturally competent, and how it can be incorporated into all aspects of the curriculum. There is attention being paid to faith-based resources as well.

An educator in the audience added they have a 2-day faculty retreat once a year, and that is the arena they have used to address these issues, but beyond that it has been single initiatives to get faculty involved, working at agencies, etc.

Dr. Russ posed the question to educators, what is your sense of where your school is at as compared with other schools with their curricula in this area?

Mr. Caldwell stated that he has the sense that they are a little ahead partly because that they take part in these discussions, but not light years ahead.

Ms. Riemersma stated that schools are all over the map, but because she talks with a lot of schools, students, and supervisors, she sees an evolution in the students she is talking to. Used to be largely white, middle-aged and female, but seeing a transformation. Schools are seriously looking at these issues and have had a shift in thinking in that this license, which was once a private practice only profession, is not that way anymore.

Mr. Wigg stated that it is a concern that the schools can be addressing these issues at an academic level, but we lose accountability when it comes to supervision.

The meeting adjourned for lunch at 12:20 p.m. and reconvened at 1:22 p.m.

IV. Solicitation for Responses From Stakeholders Regarding:

- 1. Do the current curriculum requirements allow the schools the flexibility to incorporate the new research and core competencies as established by the AAMFT, the DACUM and the MHSA?**
- 2. Are there topics or types of training that need to be mandated in order to guarantee public safety when MFTs practice in private practice and public agencies?**
- 3. Is the 48 unit requirement sufficient to cover state mandated requirements that have accumulated the core competencies for both private and public practice? Should the state consider a 60 unit requirement for licensure as an MFT?**

Dr. Russ thanked everybody for their participation, encouraged others to get the word out, then restated the three issues under the fourth agenda item.

Mr. Bruff stated that the current curriculum requirements do allow enough flexibility to incorporate new and emerging competencies. Their program consists of 57 units, which includes the 48 units required by the Board. If this requirement went higher, they would have less flexibility as they would be trying to take on new material in addition to that which is already being covered.

Ms. Riemersma stated that the Board may get push back from the schools if they increase unit requirements, as many of the programs are already more than 48 units, but Business and Professions Code (BPC) Section 4980.37 needs to be addressed. It generally states the coursework that is needed, but this needs to be enhanced to address those things we are talking about today. It is very generally stated without putting numbers on it.

Mr. Caldwell stated that if the Board increases units, it presents an access problem in terms of the higher cost. Each time they add a 3-unit course, that is another \$3,000 cost to the student.

Mr. Wigg asked his students what they thought about a 60-unit program, and one person responded you might as well get a doctorate.

Ms. Terry stated that she is currently running a 60-unit program and would rather focus on the knowledge base needed, and how that is framed within the 48 unit requirement. Another important focus should be modifying the 150-hour practicum requirement, as it is not enough. The framing of that experience might be helpful in supporting community-based practice.

Dr. Russ asked the audience to review BPC Section 4980.37 and asked what should be added.

Ms. Riemersma stated that somewhere we need to emphasize culture and linguistic proficiencies, the recovery model and resiliency and those things emphasized under the MHSA.

Mr. Caldwell stated his agreement with Ms. Riemersma. He added that specific to diversity, we are talking about more than ethnicity, which is now how many courses are focused. He suggested adding under BPC Section 4980.37(a)(3) "across a variety of public and private work settings."

Mr. Wigg from Pepperdine stated that the phrase "a variety of psychotherapeutic techniques" as stated under BPC Section 4980.37(a)(5), is vague, but in the exam the competency areas are very specific. Could we include the recovery model in the licensing exam?

Mr. Caldwell stated that if students know it is going to be on the exam, they will demand that we teach it.

Mr. Bruff suggested adding something about systems of care.

Mr. Riches asked if BPC Sections 4980.37 and 4980.40 are overlapping or completely separate. Want to make sure it reads as a coherent whole.

Ms. Pines believes there is overlap. She wanted to mention that it would be good to have an addition to BPC Section 4980.37(b) where schools are required to include public and private (nonprofit) settings in practicum according to MHSA standards.

Ms. Terry stated that is it time to expand the language under BPC Section 4980.37(a)(3) to application of couple and family relationships and other significant systems as well as the intersection of family to clients and community systems. This would highlight consumer involvement.

Ms. Loewy believes that students are not well trained to document psychotherapy in a way that conceptually makes sense and ties together treatment goals with the ongoing

treatment process. This is a problem in both public and private settings. It is a way of thinking about delivering services and treatment planning.

Ms. Riemersma stated that it is important not to overlook individuals, couples, families and children and other kinds of relationships. All need to be adequately addressed. She wants to see components of the MHSA addressed, but cautioned about using the MHSA terminology, as the terminology may change.

Ms. Thompson stated that that we should be addressing, in conceptual framework, that we will not only will follow MHSA principles, we need to transform the system. Regarding documentation, about 90% of her agency's income is from public sector client, but they also see private pay clients. She sees very little difference in the quality of referral paperwork that comes in. Can't tie the problem with treatment to either private or public practice, however, there is often little documentation from private practitioners.

Ms. Terry stated her belief that there is overlap between BPC Sections 4980.37 and 4980.40.

Mr. Riches stated that staff will work on the overlap.

Dr. Russ asked the audience what else we should be talking about, given our general goal. Who else should we invite, etc.?

Mr. Wigg asked who is talking to consumers and how are those needs incorporated into the discussions?

Dr. Russ stated that he and Mr. Riches are working on ways to do that. They have also spoken with Mr. Schroeder about ways to do that.

Mr. Riches stated that a partner (consumer) focus group would be a great way to get unfiltered, unrestrained input, to give them center stage.

Mr. Schroeder stated that it is hard because many consumers do not have transportation. If the Board wants their input, we should show that we value it by paying them. Many will not do that for free. The state has done that and expanded their expert pool to 400 people. They are paid only \$10 an hour, but it says we value your input.

Mr. Riches stated that the Board will look into that.

A member of the audience stated that her agency started with a pool of 20 experts doing Medi-Cal oversight reviews. That model expanded to other departments including the DMH. If nothing else comes out of this, it has to be consumer driven. She mentioned that a new DACUM will be done on peer supports.

Ms. Thompson stated that there should be outreach to families included. Many have been working very hard for their family member in the system and can be enormously helpful.

Ms. Terry stated her belief that regarding the knowledge base, being able to critique research is important if you're going toward evidence-based practice.

Ms. Riemersma stated that she sees the value and need for research, but does not see this as a component that the Board should be getting into, more at the schools' discretion.

Mr. Schroeder stated that knowledge is great but doesn't always translate into good practice. Life experience is very important. It really makes a difference to hear it from someone who has been there.

Ms. Thompson stated that her agency has a "Rise Above Stigma" panel, which speaks every year to 300 students. It is composed of different people, mostly clients and a family member. She has had responses back from educators that they could see significant difference toward people with a mental illness in the classroom after having a real experience. They hadn't experienced it that way before.

Ms. Riemersma mentioned that the Southern California Consortium is meeting on the same day in December as the next meeting of this committee. Mr. Riches responded that staff will look into changing the meeting location.

V. Suggestions for Future Agenda Items

The meeting adjourned at 2:11 p.m.

Agenda Item IV:

Review and Approval of
December 8, 2006
Committee Meeting Minutes

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**BOARD OF BEHAVIORAL SCIENCES**

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Meeting Minutes
Marriage and Family Therapist Education/Curriculum Committee
December 8, 2006
Phillips Graduate Institute
5445 Balboa Avenue
Encino, CA 91316

Committee Members Present:

Dr. Ian Russ, Chair
Donna DiGiorgio
Karen Pines

Staff Present:

Paul Riches, Executive Officer
Mona Maggio, Assistant Executive Officer
Christy Berger, Legislation Analyst
Justin Sotelo, Regulation Analyst

I. Introductions

The meeting was called to order at 9:05 a.m. Dr. Russ thanked Jose Luis Flores and Phillip's Graduate Institute for their hospitality in accommodating the Committee meeting. He stated that the Committee's goal is to increase the input from stakeholders as the MFT curriculum is reviewed. He explained that the MFT curriculum is mandated by the state, and the Committee is examining those mandates and will be rewriting them in some form. The more educational and agency representatives that are involved in this process, the better the results will be.

Ms. Pines and Ms. DiGiorgio of the Committee and the audience members introduced themselves.

II. Discussion of the Recovery Model and its Core Elements

Dr. Russ explained that the Committee discussed the recovery model at its last meeting, and those in attendance found that there was little agreement on what the recovery model actually is, even though its use is mandated by the Mental Health Services Act (MHSA). Mr. Riches was able to find an explanation of the recovery model from the U.S. Department of Health and Human Services, included in the packets. MHSA is saying this is another way of handling diagnosis and treatment of mental health, and it is a core part of the MHSA. The questions are what role would this have in the formal education and training of MFTs, is this something that should be mandated as part of the MFT curriculum, and if so, how? Dr. Russ asked individuals from agencies if and how the recovery model is being used.

Mr. Riches stated that there is a lot of discussion with the Board about MHSA, public practice and all of the dynamic changes because this is really a new idea. It is not the sole focus, and the medical model has been there for a long time, but licensees need to be prepared to work in any environment, including a public setting.

An audience member, a private CBO who contracts with Santa Barbara County, who oversees a community treatment program, stated that an important factor is allowing more flexibility for MFT interns in county mental health. A lot of learning comes from this type of internship, much more so than private practice experience. For example, working with people in their homes, in the hospital and doing on-call crisis work.

Another audience member works for an agency on contract with the Los Angeles Department of Mental Health (DMH). She has been working on the core competency committee of the MFT consortium, which has also been looking at the MFT curriculum. They have incorporated the recovery model throughout their recommendations. Through the county, there has been training on the recovery model for staff and others. It is a way of approaching consumers, working with them, and including them in their own treatment.

Dr. Russ asked people to also address how agencies are dealing with a medical DSM-IV model along with the recovery model.

Mr. Riches asked for clarification about the core competency committee's recommendation, if they determined whether the recovery model should be integrated throughout the curriculum as opposed to separating it out. The audience member stated yes, they felt it should be integrated.

Olivia Loewy of the American Association for Marital and Family Therapy, California Division (AAMFT-CA) stated that one of the big issues regarding the recovery model is how to bill. There is a state committee through the California Institute of Mental Health called the Black, White and Grey Committee working on what is billable and what is not billable under Medicare and Medi-Cal that is incorporated as part of MHSA, and what is in-between. They are working actively right now to try and sort that out, and what is going to happen with the transformation of treatment in relation to the MHSA.

An audience member representing an agency stated that in the past they have used the psychosocial model, which is similar to the recovery model but integrates the medical model within. His agency does not bill for therapy, but instead under rehabilitative services, which include an array of services including case management, medication support, etc. One of the most important parts to the recovery model are immersion programs, which are often staffed with consumers. It is a more holistic approach.

Ms. Pines asked whether there are any aspects of a holistic or social approach that cannot be billed. The audience member stated that this was the case previously, but since the MHSA there are more flexible options.

An audience member who is an educator stated her concern that it was difficult for the Board to find material on the recovery model. She expressed her desire to not have any mandates from the board for things such as the recovery model that are not recognized generally by the educational and clinical community. As an educator, unless there is an overwhelming reason to do it, would be against squeezing anything else into the 48-unit requirement.

Mr. Riches asked for clarification from the educator by asking how much of the recovery model is truly additional, and how much are principles that would instead be refocused or given a new vocabulary. Another question is what part of this is classroom learning, to get the fundamentals, and what should be learned during practice experience.

The educator responded that all of the concepts about strength-based resources, multidisciplinary services and the postmodern perspective have been in most MFT curriculums for some time. The actual pragmatics for clinics, such as billing doesn't need to be in a master's program. She expressed her concern that if we can't find journal articles about the recovery model, is it real enough to be placed in law. Academics don't put something in a curriculum or textbook until it is much more recognized. It is very labor intensive it is to rewrite curriculum to follow a model.

Mary Riemersma from the California Association of Marriage and Family Therapists (CAMFT) stated that the recovery model should be integrated throughout a program, and is important but would not necessarily require additional units of study. Those doing the teaching need to convey differences in work settings. For example with the recovery model clinicians work side-by-side with consumers. This is a new way of thinking because if you worked with consumers in a private practice that would be considered a dual relationship. Students need these different frameworks so they are prepared for any environment.

An audience member who is the head of a DMH-contracted agency, has been very involved in the MHSA stakeholder's process, and is very familiar with billing. She does not think that DMH is asking agencies to bill for recovery. They are asking us to incorporate, under the full-service partnership, treatment that fully supports the client so that they can recover. Recovery is a mind set, a philosophy where the consumer has the right to be actively involved in the recovery process.

A student who graduated from Pepperdine's MFT program last year stated she has not heard of the recovery model, but is familiar with the components, which were part of her curriculum.

An educator from CSU Fullerton stated there is a content versus process issue. The content is already picked up in the programs, but the holistic, systemic view is a fundamental part of the MFT profession. To say there is one recovery model may be problematic, and may lead to turf wars. It is more of a process issue, how we use that language. Curriculum doesn't need to be altered to incorporate the content.

Ms. Pines stated that she teaches practicum at Pepperdine University and was talking about the MHSA to students, what it is going to be like now that MHSA is out there. She found that most field training is in agencies, not private practice. Because of that, they have a better understanding of those settings; it is not new to them.

An educator stated that he likens this to the multi-cultural requirement. One model for multicultural teaching says you teach one course, and that satisfies the requirement. Another model is teaching a cluster of courses; another model is where you integrate multicultural notions into the curriculum, that is the best way. Recovery model issues are already integrated throughout, so a separate course is not required.

Dr. Russ reiterated that what he is hearing is concern that this may not be a distinct enough model, but is rather a broad concept that is mostly in the curriculum anyway.

The educator responded that it would be difficult to teach a course on a model for which there is not peer-reviewed literature published. Dr. Russ promised to have a search of the literature done for the next meeting.

Michael Lewin from the MFT program at CSU San Bernardino stated he is not as convinced that schools are already teaching the concepts of a recovery model. He believes that MFTs have gone from private practice to doing much more work in the community mental health arena. So, are we training our students to do a good job in public mental health, or are we still stuck in a private practice mentality in our coursework? He believes it is still more private practice focused. It would be nice to have a more organized way to prepare students for community mental health.

Claudia Shields, training director at Antioch University stated she has a different perspective. Her first reaction was that they do teach some theoretical concepts of the recovery model, but on second, deeper look, this is not happening on a practical level.

An audience member who is a social worker stated that the MHSA is more outcome-driven, it is not just about symptom reduction. The medical model is used because you are assessing the clients and giving psychiatric care, but the principles of consumer-directed treatment are integrated, which is new to all of the mental health professions. We are not used to consumers leading groups, being involved in program planning, etc.

An audience member stated that her agency hasn't started teaching the recovery model to staff, as the DMH hasn't determined which recovery model they will require. There is a lot of literature on different recovery models, actually too much literature to sort through. It will take some time before we know which model DMH wants us to use.

Ms. Riemersma stated that additional courses should not be required, but the language of the recovery model needs to be integrated into the law so that it can be addressed within the programs. Needs to be recognition drawn to this model.

Mr. Riches stated from a regulator's standpoint that many of the educational requirements are stated at a high level of generality. They don't reference any particular school of therapy, and they should stay that way. What is in there are the core principles in the broadest sense, the domains of knowledge. He is sympathetic to educators regarding anxiety about adding content. He clarified that we are looking at integrating this perspective, not picking one specific type of recovery model to teach.

Ms. Loewy stated that a previous meeting discussed the distinction between curriculum and competencies. There were a lot of efforts from different groups to determine whether existing competencies are covering what needs to be learned in order to work effectively in the public system. So if there is a gap in the competencies, that may be something to look at. In terms of designating what kind of curriculum needs to be taught, they previously discussed letting schools develop their own curriculum that will result in the students having those competencies.

Diane Gehart from CSU Northridge stated that there isn't anything in MFT literature that has the recovery model in it, and it is not mentioned in current textbooks. Students can get a description of the recovery model and identify how it has integrated different therapy models such as humanistic and others. So giving students the foundational tools is important. She is concerned about legislating this model because it is more of a

philosophy and is hard to legislate a spirit, a set of values, or what seems like an ethical principle.

III. Discussion Draft for Revising Curriculum Statutes

Dr. Russ stated that this is not a true draft, but a way of framing previous discussions. He asked Mr. Riches to present it.

Mr. Riches stated that the statute as written is a cumbersome patchwork that contains duplications and is not clear. This committee presents an opportunity to revisit the requirements to make them more manageable and to look at the individual mandates and align them into a coherent whole. This is an opportunity to have government catch up with the real world.

Dr. Russ stated that he has been studying board forms and is learning how the schools ensure that they are meeting the requirements. He expressed his appreciation that schools' personal characteristics are very exciting, as long as there is a basis for people to come out as qualified. He asked what needs to be in a curriculum that is going to prepare students the best, and what of that should be a mandate.

Ms. Riemersma thinks that it is good to have all educational requirements in statute. She stated that draft subparagraph (a)(6) regarding treatment of children refers to regulations, but there are no regulations. We have managed to go since 1986 like this, so maybe regulations are unnecessary. Regarding (b)(5)-(10) there need to be protections for people in the pipeline since these courses would become part of fully integrated program. A timeline should be added so that people who already began their program aren't disadvantaged.

Mr. Riches stated that when we have an actual proposal we will need to include a timeline to give programs time to implement programs. This is all a very future oriented discussion and will not move quickly. He agrees that we do not want to write curriculum in regulation.

An audience member expressed her approval of the draft, felt it does a good job of eliminating duplication. She asked what does "within the degree" mean? For example, child abuse is currently a separate course, but is now proposed to be within the degree. Can schools provide this as an extension or continuing education course? Is it deliberately written vaguely?

Mr. Riches stated that the course would need to be credit level. The mode of delivery is the educational institution's responsibility, it doesn't matter to us. One of the foundational questions for us is, from a consumer's standpoint, shouldn't a professional degree program required to get a license include all the classes needed to get your license? Also the draft proposes this change because some of these courses are now only required prelicensure, but shouldn't you know things such as child abuse reporting before you get your intern registration?

An audience member asked for clarification about whether the courses could be offered at the extension level if they appeared on the transcript.

Mr. Riches stated a narrow interpretation based on this draft would be no, they would have to be credit level, but we can discuss this further.

Dr. Russ asked why a school would prefer to offer these as non-credit level courses.

The audience member responded that this is how they currently do it, and are a little unclear about whether what they are doing is the right thing for students.

Dr. Russ asked what difference it would make to schools whether these are required as for-unit courses or allowed as extension courses.

An audience member stated that they have already gone from 48 units to 60 units just to meet the requirements, so adding units would be difficult.

Another audience member stated it was confusing, it seems like you are bringing more into the degree program. He would prefer to discuss the timing of these courses of whether it should be learned prior to internship or prior to licensure.

An audience member from Phillips stated that there are financial aid considerations with number of units. Going up to more units is not necessarily a negative thing, but federal financial aid barely covers everything as it is. This is more of an issue at private schools. We can offer extension courses at a much lower cost at a student rate while they are in their degree program.

Mr. Riches stated that it sounds like schools need flexibility of requiring the content without specifying units or hours. There are a couple of models that can be looked at.

An audience member stated if you require new content only as coursework, you are disqualifying individuals that are already licensed. If these are offered as extension courses, licensees can also take them.

Mr. Riches explained that we are talking about the curriculum, which is a separate discussion from licensed population.

Dr. Russ mentioned how difficult it is for people licensed out of state to get the courses they need to become licensed.

Mr. Riches stated that the MHSA is challenging everybody's practice models and everyone is at a different starting position.

The Committee adjourned for a break at approximately 10:30 a.m.

Dr. Russ stated his appreciation of the discussion and encouraged ongoing audience participation at future meetings, and asked people to invite others whose points of view may not have been heard so far.

An audience member felt that the statute contains antiquated language regarding cross-cultural mores; there should be more emphasis on cultural competence and working with underserved populations.

Dr. Russ offered his email address and encouraged the audience to notify him regarding suggested edits to the language.

Another audience member asked for clarification about what “integrated” means. The notion of integrated seems to mean that you take all of the classes as part of your degree, but it is not clear. These are concepts put into the law, but are not clearly defined.

Ms. Riemersma stated that the language goes back to when the language was redrafted back in 1986. Marriage and family therapy is to be integrated throughout every course, as opposed to being taught a generic counseling program and then having marriage and family therapy courses thrown in.

IV. Discussion of Patient Composition at Public Mental Health Agencies

Dr. Russ stated that the statistics from the DMH provide an interesting look at diagnoses in public mental health. If we are preparing people for licensure, we need to know what people are doing once they get licensed. We need to know what kind of diagnoses are being treated, and this provides a breakdown by different demographics. Underserved communities by definition are not represented in the statistics. Another limitation is that you have to have a diagnosis in order to get treated and this can skew statistics at times. If you look at the national census, which is not here, it shows that approximately 20% of adults and children have some kind of psychiatric diagnosis. Another factor is difficulty in diagnosing children especially, as their diagnosis may change over time.

Ms. DiGiorgio asked for an estimate about what percentage of the population is not being served.

Sherry Brill from the Center for Individual and Family Counseling stated that the uninsured are in great need of affordable mental health care. She has people who can't afford \$15 a week but are in dire straits needing therapy. There is very limited help for these people.

Mr. Riches asked whether students are being prepared for the population they are going to see.

An audience member asked whether these were the most recent statistics, as they are dated 1998. Mr. Riches stated that these were the most recent statistics provided on DMH's web site. The audience member stated that demographics have changed recently so she is concerned about the age of the statistics. Her sense is that the programs could only prepare people so much, and feels that the experience counts for a lot. Teamwork needs to happen between the schools and placements.

Another audience member stated she had been supervising students, and feels that certain things could be emphasized in the curriculum to better prepare students, such as case management, resources and progress notes. A lot of students aren't familiar with how to access resources or do case management.

Another audience member from an Asian counseling center in LA County stated that language is a big issue. Also the unserved and inappropriately served populations. In the Asian population, for every Asian they are seeing there are 7-8 others who do not come in for various issues, such as language, transportation, etc. We don't know how many will

never go there because they don't believe in mental illness or feel stigmatized. There are some cultures that don't have a concept of mental illness.

Dr. Russ stated he would like schools to comment on how they are doing with providing cultural competency training.

An audience member stated she has seen progress in this area. Would like to see more progress in readiness to serve underserved populations. People need to know how to do more than just therapy, they need to know what the MHSA is, they need to know what CalWorks is.

A director of clinical services at Jewish Family Services of LA stated that MFT students are often unwilling to do certain administrative functions such as paperwork because they can't count these types of hours toward licensure. Feels that they are being prepared more for private practice, stemming from the traditional structure. It would be great to educate them about what they need to do to work across different agencies and cultures.

Ms. Pines stated that she found, while working as the director of a social work agency, that MFT students' desire to do this type of work is a very individual thing. If we are going to have community mental health, maybe it needs to be reflected in the law so that they don't have this opposition.

Dr. Russ expressed his desire to fix this problem as quickly as possible, to get it to the Board.

Another audience member who receives MHSA funding through the full service partnership states that MFT students don't want to work under the full service partnership because they can't earn their hours that way.

Dr. Russ asked people from agencies to email him describing what the fix is for this problem.

Ms. Brill stated that another problem is about half of the students who come looking to be employed do not have any experience with their own personal psychotherapy. She would hesitate to put a therapist into a room with a client when they don't have this experience.

Dr. Russ stated that we can accept hours of psychotherapy toward licensure, but it would be difficult to require it. This would need to be required by the schools, and agencies should let the schools know they are not interested unless people have these qualifications.

V. Discussion of Desired Skills in Public Mental Health Agencies

An audience member stated that we are looking at a paradigm change, the consumers of mental health have said "nothing about us without us." Their perspective is now being brought into the process. Almost half of his staff are consumers of mental health in other agencies, and they help to keep him in check. He also mentioned that cultural sensitivity is more important than cultural competence, for example, you can study one culture for years and still not be competent. We need to think a little bit differently.

Another audience member stated that we are sending people out to do therapy in practicum after only six months to one year in the program, and she is concerned whether people are ready at this point, and whether we are able to define “readiness.” We also assume that faculty is competent to teach cultural competence, so this is a very complex experiment that we are in the middle of. She doesn’t think anybody can be ready with 150 clinical practicum hours – this is a short experience and there is a time and intensity issue.

Dr. Russ stated he is not as concerned about practicum hours, but is more concerned about post-degree experience, whether people are getting enough.

Another audience member stated that his program is a heavily private practice oriented model, though his students do work in community mental health and his students tell him they have a big adjustment. Part of it is cross cultural, doing a better job at treatment planning, and operationally defining goals.

Another audience member expressed her opposition to adding to the 150 hours of practicum because most people get more than that anyway, they just can’t count them.

Another audience member stated that a large number of trainees are working in schools, and doesn’t see that reflected in the conversation. As a profession we need to do a lot more to prepare them. Another issue is that interns feel as if they are being used as “slave labor.” They don’t get appropriate supervision, and more time is spent on billing issues instead of clinical issues.

An educator from CSU Long Beach has a class on cross-cultural counseling and infuses issues of diversity into all courses. This year opened up a clinic where they provide live supervision. Cross-cultural competency has turned out to be a huge issue for students even though they thought we believed we were doing a good job preparing them. Students often don’t really know what to do with it practically, they are spending a lot of time in supervision working on these issues.

An audience member from Phillips runs an agency in South Central Los Angeles, and works with many MFT students. More than readiness, we need more students that are willing and have the right attitude about working with people of color. She believes we can’t get them ready for everything, but she can work with anybody who is willing.

Another audience member stated that some of this discussion is a professional identity piece. MFTs are more and more seen as front line providers in community mental health and there is a recognition that MFTs need to be leading the field in this area. A lot of times students don’t know what they can do with this license. It has always been illegal for trainees for work in private practice, so they have to work in an agency in order to become an MFT. It has always been a part of the training, so now we’re just being more open about it.

Another audience member stated that one area not addressed are skills in outreach and engagement. You’re not going to get the clients unless you know how to outreach to them by going to their churches, community functions, being part of the community. Also regarding interns as “slave labor,” a lot of the DMH contracted agencies do pay their interns a salary. In her non-profit agency, interns get paid a small amount for every client seen. In another private nonprofit she has worked for the interns had to pay the agency a bit, so there is a big split between different types of agencies.

Ms. Pines stated we've come a long way today, and she is glad to see an audience from diverse areas of the profession. She feels we have a good start on a comprehensive proposal. She expressed her appreciation for all of the ideas presented today.

Ms. DiGiorgio stated the times are changing quickly and more is being realized about the integration of different types of issues. It is good to see professions working together without a turf war, working for the consumer and that is great.

Dr. Russ stated that in the end, we're going to come up with a proposal, and if these discussions with agencies, government and school are able to grow in the community, this is the greatest thing this committee can offer. We are looking at minimum requirements for licensure, but the discussion here is bigger than that, it is also about how we are going to serve underserved communities. He explained that the next meeting of this committee will be in March, but we are not sure yet of the location.

VI. Suggestions for Future Agenda Items

No suggestions were offered.

The meeting adjourned at approximately 12:00 p.m.

Agenda Item V:

Presentation by Marianne Baptista, MFT
On Training and Recovery Models

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MFTs in Public Mental Health: The Challenge for Educators and Supervisors

Marianne Baptista, MFT, CPRP
Training and Education Coordinator
California Association of Social Rehabilitation
Agencies (CASRA)

Preparing the Public Mental Health Workforce

- Education and training needs to address the potential discrepancies experienced by the MFT in public mental health in these areas:
 - Treatment Approach
 - Population Served
 - Treatment Methodology
 - Therapeutic Relationship
-

Treatment Approach

- Recovery-oriented
 - Person-centered
 - Focus on quality of life
 - Promotes empowerment, competency, community integration, and recovery
 - Engages the whole person
-

Population Served

- Persons living in poverty
 - Cultural issues
 - Community integration issues – benefits, fair housing, ADA
 - Persons diagnosed with serious mental illness
 - Cultural issues
 - Family dynamics
 - Best practices
 - Resources
-

Treatment Methodology

- Practitioner works as part of a team which includes relevant family and community partners
 - The community is the office
 - Services are scheduled as needed
-

Therapeutic Relationship

- Personal as well as professional
 - Boundaries are less well-defined
 - Decisions about boundaries are intentional
-

Challenges for educators

- Determine what material can be incorporated in existing courses
 - Develop a “Fundamentals of Working in Public Mental Health” course
 - Provide training experiences – practicums and internships - in public mental health settings
 - Assure that discrepancies in work experience and traditional course work are addressed in supervision
-

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Agenda Item VI:

Presentation by Rusty Selix of California
Council of Community Mental Health

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California Council of Community Mental Health Agencies: Recommendations to the California Board of Behavioral Sciences Regarding Marriage and Family Therapy Curriculum

Background

The California Council of Community Mental Health Agencies (CCCMHA) is a statewide trade association whose members are the primary providers of mental health and substance abuse services in California. CCCMHA Executive Director Rusty Selix was the lead author of Proposition 63 and, from its inception, association members had a strong role in shaping and supporting the legislation. The passage of Proposition 63 substantially changed the mental health landscape in California, creating both a critical workforce shortage and the demand for a new kind of practitioner. In response to growing concerns about the workforce provider shortage, the CCCMHA Public Policy Committee initiated a process to obtain information from the employers' perspective that could lead to proposed changes in the education and training of Marriage and Family Therapists (MFTs).

With ongoing implementation of the Mental Health Services Act, the California public mental health system is in a process of major and comprehensive transformation. Informal discussions with employers indicates that new competencies in educational programs and revised provider training is needed on a multidisciplinary level (consumer advocates to Ph.D.) and not just for MFTs. At the state level, joint efforts are currently underway to identify the cross-cutting competencies that pertain to the provision of treatment services in public mental health, regardless of provider discipline or level of education. These efforts, led by the California Department of Mental Health and the California Mental Health Planning Council, will result in the designation of overarching competencies that transcend the individual disciplines. Recognition of the unique skills and training within each discipline can then be "plugged into" a comprehensive continuum of care in relation to both the desired processes and outcomes of treatment.

In California, public mental health employers commonly link the education and training of MFTs with a somewhat general education in preparation for private practice. There is confusion about the unique skills and training of MFTs, which results in employers' questions about how or whether they can effectively fit into the public mental health system of care. This confusion makes perfect sense in California, considering the multitude of diverse graduate school educational programs that produce Marriage and Family Therapists in our state. In all other states, it is clearly understood that a Marriage and Family Therapist is trained in various forms of theories and methods stemming from a model of understanding human interaction called *Systems Theory*.

Central Connecticut State University introductory material explains: "Systems theory is an integrated set of concepts which describes how each person is interconnected with his or her context in very complex ways, and looks at the individual as simultaneously a whole entity and as part of a larger system. Systems theory holds that individuals function in relation to others and in relation to a set of circumstances that dictate how each person is to react. The MFT professional must have competence in case management procedures, including referral skills, coordination skills, and communication skills. Marriage and Family Therapy is an active approach toward intervention, and often requires that the MFT extend his or her work outside the boundaries of the consultation room during the Clinical Hour. Such activities as home visits,

conferences with teachers, visits to the probation department, coordination of treatment planning meetings with other professionals involved with a case, and many other tasks are often part and parcel of the work of the MFT. Such is in keeping with the principles of systems theory and the understanding of the complex interrelationships among parts of a system.”

Clearly, MFTs who are a product of education and training solidly based in systems theory are prepared to work in public mental health. Unification of MFT graduate school programs to incorporate a strong systems perspective would enable California public mental health employers, as well as future MFTs, to clearly understand the role of this discipline within the larger continuum of care.

CCCMHA Membership Survey

CCCMHA developed and conducted a membership survey for the purpose of obtaining employer opinions that could lead to proposed changes in MFT curriculum. The recommendations that follow are based on survey results as well as discussions among members regarding employment of MFTs in public mental health.

The CCCMHA Employer Survey (***Attachment A***) was designed to provide information regarding specific competencies as well as to elicit employers’ opinions and comments about MFT preparedness in relation to their agencies’ workforce needs. To provide additional information, agencies were also invited to include a job description for licensed clinicians.

Within the CCCMHA Employer Survey, Section A contains a list of relevant competencies extracted by the Los Angeles Consortium MFT Competencies Committee from a diversity of sources including: BBS standards (state); Council for the Accreditation of Counseling and Related Educational Programs standards (national); American Association for Marriage and Family Therapy Core Competencies (national); California Mental Health Planning Council, Human Resources Committee DACUM (state competency profile); CalSWEC Mental Health Core Competencies (state). A checklist was developed for Section A, enabling respondents to categorize specific competencies as follows: Belongs in Education Program; Best Provided by On-the-Job Training; Continuing Education Needed in This for Current Staff; Non Applicable. Respondents were able to check more than one category for each competency. Sections B – D incorporated an open-ended format and Sections E – F included short-answer response categories.

Attachment B contains the survey responses, reporting percentages for Section A, followed by a composite of the open-ended and short-answer responses in Sections B – F. ***Attachment C*** contains copies of a few of the job descriptions submitted by agencies.

Summary of Survey Results

Responses were received from 26 member agencies representing a total number of 5485 employees, 1381 positions available for MFTs and a collective budget of \$182,070,554.

CCCMHA members are not in a position to recommend specific changes in graduate school curriculum or supervised training; however, the employers surveyed are the experts in relation to designation of the education and training that will prepare MFTs to function competently within their agencies.

Competency Break-Out Results:

- In the categorization of specific competencies, there was solid consensus of responses on several items. Over 80% of the respondents agreed that the following belong in those educational programs seeking to prepare MFTs for employment in the public mental health system:

Competency 1: Solicit and use client feedback throughout the therapeutic process. (92%)

Competency 2: Evaluate individuals needs for appropriateness for treatment within professional scope of practice and competence. (81%)

Competency 3: Demonstrate knowledge of the experiences of immigrants, refugees and victims of torture and the impact of these experiences on individuals, families and succeeding generations. (81%)

Competency 4: Understand recovery-oriented behavioral health services. (88%)

Competency 12: Recognize strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit. (100%)

Competency 15: Respect multiple perspectives (e.g., clients, family, team, supervisor, practitioners from other disciplines involved in the case). (85%)

Competency 16: Set appropriate boundaries, manage issues of triangulation, and develop collaborative working relationships. (85%)

Competency 18: Integrate dual diagnosis treatment. (88%)

Competency 19: Knowledge of the principles underlying recovery supportive practice. (92%)

Competency 20: Understand and monitor issues related to ethics, laws, regulations, and professional standards. (96%)

Competency 23: Understand the developmental, intergenerational and life cycle approach to community mental health practice transculturally. (96%)

Competency 24: Understanding of the impact of mental illness and substance abuse on the consumer and family members at all stages of the life cycle. (96%)

Competency 25: Critique professional research and assess the quality of research studies and program evaluation in the literature as it relates to guiding principles. (88%)

Competency 32: Ability to write chart notations that accurately reflect the intervention, goal and result, assist in making future decisions, support billing, reflect the role of the client in the treatment process and choices of goals and treatment activities. (85%)

Competency 33: Understanding the concept of evidenced based treatment; development of evidence to evaluate promising practices. (88%).

- Similarly, there was solid consensus regarding the competencies, best provided by on-the-job training, including:

Competency 6: Develop with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans. (85%)

Competency 7: Work collaboratively with stakeholders, including family members, other significant persons and professionals who are significant to the client. (81%)

Competency 8: Advocate in partnership with clients in obtaining quality of care, appropriate resources, and services in the community. (92%)

Competency 10: Assist clients and family members to understand and navigate the public mental health system. (96%)

Competency 11: Participate in quality assurance. (96%)

Competency 13: Empower clients and their relationship systems to establish effective relationships with each other and larger systems. (85%)

Competency 14: Provide psychoeducation to clients and families whose members have serious mental illness or other disorders, including information about wellness and recovery. (88%)

Competency 15: Respect multiple perspectives (e.g., clients, family, team, supervisor, practitioners from other disciplines involved in the case). (85%)

Competency 17: Assist in obtaining and maintaining educational and vocational goals (85%)

Competency 22: Provide education in parenting skills and/or foster parenting skills (85%)

Competency 28: Complete billing procedures and charting documentation to support billing. (96%),

Competency 29: Handle consumer family complaints and grievances (96%)

Competency 31: Understand Medi-Cal, Medicare and Social Security eligibility. (81%)

Competency 32: Ability to write chart notations that accurately reflect the intervention, goal and result, assist in making future decisions, support billing, reflect the role of the client in the treatment process and choices of goals and treatment activities. (96%).

Open-Ended Responses

A review of the open-ended responses confirms that employers commonly perceive MFTs as being trained for private practice rather than community work. Consistent themes emerged in relation to the skills, knowledge and attitude that public mental health system employers look for, including:

- Preparation for community based practice and environment.
- Ability to work in an interdisciplinary team.

- Willingness to provide services to clients in their natural settings, such as home, school, church, etc.
- Sensitivity to and knowledge of the special conditions, ethnic and cultural characteristics of the diverse populations in need of treatment.
- Willing to work with consumers and their families in a joint treatment process.
- Ability to diagnose and then use these diagnoses in the development of treatment plans and the implementation of service delivery.
- Ability to document services in the form of clear, concise progress notes and reports in a manner that meets agency deadlines and government standards.
- Substance abuse training.
- Exposure to evidence based practice, outcome and evaluation.

Recommendations

As a discipline, Marriage and Family Therapists comprise the largest number of licensed mental health professionals in the state of California. Facing a critical workforce shortage, public mental health agencies want to perceive and include MFTs as strong candidates for employment. Based on the survey responses, CCCMHA has developed the following recommendations:

- Marriage and Family Therapists who receive solid and predominant training in Systems Theory will have a clinical perspective that is relevant to the provision of treatment in public mental health.
- To ensure that employers eventually gain confidence in MFT preparedness, it is recommended that revisions be incorporated in graduate school curriculum and in licensure requirements to secure equal status among licensed professionals in relation to employability in the public system. Changes at this fundamental level will provide valuable benefits in response to the increasing workforce needs as well as to the MFT profession.
- MFT curriculum must embed and continuously address the following essential elements:
 - Focus on wellness, recovery, resilience
 - Cultural competence
 - Consumer/family driven services
 - Consumer/family members integrated throughout the mental health system
 - Community collaboration.
- Beyond skills and knowledge, employers look for a personal attitude that encompasses the spirit of the Mental Health Services Act: teamwork; inclusiveness; respect; belief in recovery. They are seeking potential employees who will do “whatever it takes” in order to provide whatever it takes. While it may seem quite challenging to teach attitude, it is possible to model, within educational programs, a system built on a spirit of inclusion and respect, by opening up the classroom to non-traditional teachers and methods of instruction. Educational programs can be developed to simulate the environment that MFTs will be entering into if they choose to work in the public system. It is recommended that graduate school programs incorporate additional subject matter material as well as revised methods of instruction designed to provide students with the skills, knowledge and attitudes that employers have indicated would adequately prepare MFTs to work in public mental health.

- Given the ongoing transformation of treatment services in public mental health, employers are faced with a multitude of training and retraining needs that pertain to the current as well as the future workforce. Employers recognize that even those providers historically perceived as trained to work in the public system lack adequate preparation in this continually evolving treatment environment. Employers recognize that their staff training needs are all encompassing. CCCMHA representatives are paying close attention to the CiMH Recovery Medi-cal Discussion Project. CiMH is presently developing curriculum with County and Agency supervisors/lead staff and QI managers who will be attending "Train-the-Trainers" sessions at the regional level. The material will provide content modules designed to promote person-centered, culturally competent work that can survive the scrutiny of Medi-Cal audits. To ensure for relevance and credibility, CCCMHA recommends that any additional specialty training for MFTs be provided in multidisciplinary settings and offered directly through the state mental health system, the counties, or their contracted agencies.

For questions, comments or suggestions, you may contact:

- Rusty Selix, CCCMHA Executive Director at (916) 557-1166 or rselix@cccmha.org;
or
- Adrienne Shilton, CCCMHA Senior Policy Analyst at (916) 557-1166 or ashilton@cccmha.org

ATTACHMENT A

CCCMHA EMPLOYER SURVEY

Name of Agency: _____

Location: _____ Approx. # of Employees: _____

Approx # of positions appropriate for MFT trained individuals _____

- A. Please review the list of Competencies below and check the appropriate box. You may check more than one box for each item.

COMPETENCY	BELONGS IN EDUCATION PROGRAM	BEST PROVIDED BY ON- THE-JOB TRAINING	CONTINUING EDUCATION NEEDED IN THIS FOR CURRENT STAFF	NON APPLICABLE
1. Solicit and use client feedback throughout the therapeutic process.				
2. Evaluate individuals needs for appropriateness for treatment within professional scope of practice and competence				
3. Demonstrate knowledge of the experiences of immigrants, refugees and victims of torture and the impact of these experiences on individuals, families and succeeding generations.				
4. Understand recovery-oriented behavioral health services (e.g. self-help groups, 12-step programs, peer-to-peer services, supported employment)				
5. Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan				
6. Develop with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans.				
7. Work collaboratively with stakeholders, including family members, other significant persons and professionals who are significant to the client.				
8. Advocate in partnership with clients in obtaining quality care, appropriate resources, and services in the community				
9. Develop a service plan for case management and supportive services.				
10. Assist clients and family members to understand and navigate the public mental health system				
11. Participate in quality assurance				
12. Recognize strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit.				
13. Empower clients and their relational systems to establish effective relationships with each other and larger systems.				

ATTACHMENT A

14. Provide psychoeducation to clients and families whose members have serious mental illness or other disorders, including information about wellness and recovery				
15. Respect multiple perspectives (e.g. clients, family, team, supervisor, practitioners from other disciplines involved in the case.)				
16. Set appropriate boundaries, manage issues of triangulation, and develop collaborative working relationships				
17. Assist in obtaining and maintaining educational and vocational goals				
18. Integrate dual diagnosis treatment				
19. Knowledge of the principles underlying recovery supportive practice				
20. Understand and monitor issues related to ethics, laws, regulations, and professional standards.				
21. Demonstrate knowledge of adult and child systems of care and coordinated service				
22. Provide education in parenting skills and/or foster parenting skills.				
23. Understand the developmental, intergenerational and life cycle approach to community mental health practice transculturally				
24. Understanding of the impact of mental illness and substance abuse on the consumer and family members at all stages of the life cycle.				
25. Critique professional research and assess the quality of research studies and program evaluation in the literature as it relates to guiding practice.				
26. Assist in enrollment for financial entitlements and provide benefits counseling.				
27. Coordinate treatment and discharge planning in higher level treatment facilities				
28. Complete billing procedures and charting documentation to support billing.				
29. Handle consumer family complaints and grievances				
30. Participate in program development and design				
31. Understand Medi-Cal, Medicare and Social Security eligibility				
32. Ability to write chart notations that accurately reflect the intervention, goal and result; assist in making future decisions; support billing; reflect the role of the client in the treatment process and choices of goals and treatment activities.				
33. Understand the concept of evidenced based treatment; development of evidence to evaluate promising practices,				

ATTACHMENT A

Additional competencies needed, but not listed:

Comments:

B. Is the educational system producing graduates who are adequately prepared to provide services in public mental health? ____ Yes ____ No

Comments: _____

C. What are the most important skills/knowledge/experience necessary for a candidate to be job-ready for your agency? (Please list)

Comments: _____

D. What are the skills/knowledge/attitudes that are most effectively developed on-the-job at your worksite?

Comments: _____

E. Would it influence your hiring decision if a candidate held a specialty certificate in Public Mental Health offered by a professional association or private business? (You may check more than one).
____ Our hiring decisions are based on a diversity of factors beyond prior coursework or external indicators of competency
____ With adequate changes in the educational curriculum a certification process would be superfluous.
____ With adequate changes in the educational system, we would prefer to provide on-the-job training specific to our site and operations.
____ With adequate changes in the educational curriculum, we would also prefer to have available CEU opportunities to continue developing and improving skills needed in the public sector.
____ We would be most likely to hire a candidate who produced a specialty certificate.

ATTACHMENT A

F. Would the requirement or options to have a special certificate for serving the public sector contribute to or add barriers to the availability to an adequately trained workforce for public sector agencies? ____Contribute ____Add Barriers ____Undecided

Comments:_____

Survey Completed By:_____Date:_____

Title:_____

ATTACHMENT B

SURVEY RESPONSES

Total # of Employees: 5485
Total # of Positions Appropriate for MFT Trained Individuals: 1381

Competency Breakout and Results

Key for breakout results listed below

- 1: *Belongs in education program***
- 2: *Best provided by on-the-job training***
- 3: *Continuing education needed in this for current staff***
- 4: *Not applicable***

Competency 1: Solicit and use client feedback throughout the therapeutic process

- 1: 24 = 92%
- 2: 18 = 69%
- 3: 10 = 38%
- 4: 0 = 0%

Competency 2: Evaluate individuals needs for appropriateness for treatment within professional scope of practice and competence

- 1. 21 = 81%
- 2. 16 = 62%
- 3. 9 = 35%
- 4. 0 = 0%

Competency 3: Demonstrate knowledge of the experiences of immigrants, refugees and victims of torture and the impact of these experiences on individuals, families and succeeding generations

- 1. 21 = 81%
- 2. 14 = 54%
- 3. 19 = 73%
- 4. 1 = 3.8%

Competency 4: Understand recovery-oriented behavioral health services

- 1. 23 = 88%
- 2. 15 = 58%
- 3. 15 = 58%
- 4. 0 = 0%

ATTACHMENT B

Competency 5: Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan

1. 20 = 77%
2. 20 = 77%
3. 15 = 58%
4. 0 = 0%

Competency 6: Develop with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans

1. 17 = 65%
2. 22 = 85%
3. 16 = 62%
4. 0 = 0%

Competency 7: Work collaboratively with stakeholders, including family members, other significant persons and professionals who are significant to the client

1. 18 = 69%
2. 21 = 81%
3. 11 = 42%
4. 0 = 0%

Competency 8: Advocate in partnership with clients in obtaining quality of care, appropriate resources, and services in the community

1. 13 = 50%
2. 24 = 92%
3. 10 = 38%
4. 0 = 0%

Competency 9: Develop a service plan for case management and supportive services

1. 19 = 73%
2. 20 = 77%
3. 7 = 27%
4. 0 = 0%

Competency 10: Assist clients and family members to understand and navigate the public mental health system

ATTACHMENT B

1. 10 = 38%
2. 25 = 96%
3. 12 = 46%
4. 0 = 0%

Competency 11: Participate in quality assurance

1. 11 = 42%
2. 25 = 96%
3. 9 = 34%
4. 1 = 3.8%

Competency 12: Recognize strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit

1. 26 = 100%
2. 14 = 54%
3. 17 = 65%
4. 0 = 0%

Competency 13: Empower clients and their relationship systems to establish effective relationships with each other and larger systems.

1. 15 = 58%
2. 22 = 85%
3. 15 = 58%
4. 0 = 0%

Competency 14: Provide psychoeducation to clients and families whose members have serious mental illness or other disorders, including information about wellness and recovery

1. 17 = 65%
2. 23 = 88%
3. 19 = 73%
4. 0 = 0%

Competency 15: Respect multiple perspectives (e.g., clients, family, team, supervisor, practitioners from other disciplines involved in the case)

1. 22 = 85%
2. 22 = 85%
3. 12 = 46%
4. 0 = 0%

ATTACHMENT B

Competency 16: Set appropriate boundaries, manage issues of triangulation, and develop collaborative working relationships

1. 22 = 85%
2. 21 = 81%
3. 13 = 50%
4. 0 = 0%

Competency 17: Assist in obtaining and maintaining educational and vocational goals

1. 14 = 54%
2. 22 = 85%
3. 8 = 31%
4. 1 = 3.8%

Competency 18: Integrate dual diagnosis treatment

1. 23 = 88%
2. 19 = 73%
3. 19 = 73%
4. 0 = 0%

Competency 19: Knowledge of the principles underlying recovery supportive practice

1. 24 = 92%
2. 15 = 58%
3. 12 = 46%
4. 1 = 3.8%

Competency 20: Understand and monitor issues related to ethics, laws, regulations, and professional standards

1. 25 = 96%
2. 18 = 69%
3. 17 = 65%
4. 0 = 0%

Competency 21: Demonstrate knowledge of adult and child systems of care and coordinated service

1. 16 = 62%
2. 20 = 77%

ATTACHMENT B

3. 10 = 38%
4. 0 = 0%

Competency 22: Provide education in parenting skills and/or foster parenting skills

1. 18 = 69%
2. 22 = 85%
3. 15 = 58%
4. 0 = 0%

Competency 23: Understand the developmental, intergenerational and life cycle approach to community mental health practice transculturally

1. 25 = 96%
2. 15 = 58%
3. 16 = 62%
4. 0 = 0%

Competency 24: Understanding of the impact of mental illness and substance abuse on the consumer and family members at all stages of the life cycle

1. 25 = 96%
2. 16 = 62%
3. 16 = 62%
4. 0 = 0%

Competency 25: Critique professional research and assess the quality of research studies and program evaluation in the literature as it relates to guiding principles

1. 23 = 88%
2. 6 = 23%
3. 8 = 31%
4. 1 = 3.8%

Competency 26: Assist in enrollment for financial entitlements and provide benefits counseling

1. 7 = 27%
2. 20 = 77%
3. 9 = 35%
4. 2 = 7.8%

Competency 27: Coordinate treatment and discharge planning in higher level treatment facilities

ATTACHMENT B

1. 12 = 46%
2. 20 = 77%
3. 7 = 27%
4. 2 = 7.8%

Competency 28: Complete billing procedures and charting documentation to support billing

1. 9 = 35%
2. 25 = 96%
3. 11 = 42%
4. 1 = 3.8%

Competency 29: Handle consumer family complaints and grievances

1. 5 = 19%
2. 25 = 96%
3. 7 = 27%
4. 2 = 7.8%

Competency 30: Participate in program development and design

1. 13 = 50%
2. 20 = 77%
3. 8 = 31%
4. 1 = 3.8%

Competency 31: Understand Medi-Cal, Medicare and Social Security eligibility

1. 15 = 58%
2. 21 = 81%
3. 12 = 46%
4. 0 = 0%

Competency 32: Ability to write chart notations that accurately reflect the intervention, goal and result, assist in making future decisions, support billing, reflect the role of the client in the treatment process and choices of goals and treatment activities

1. 22 = 85%
2. 25 = 96%
3. 17 = 65%
4. 0 = 0%

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Competency 33: Understanding the concept of evidenced based treatment; development of evidence to evaluate promising practices

1. 23 = 88%
2. 20 = 77%
3. 19 = 73%
4. 0 = 0%

Open-Ended Responses

ITEM B. Is the educational system producing graduates who are adequately prepared to provide services in public mental health?

- Need more bilingual grads!!!!
- Very disconnected, very out of step 15 years behind contemporary movements
- They are geared for private practice rather than community work
- In addition to reducing the differences in academic preparation, there seems to be a clear need for greater vigilance regarding pre-degree field placement experience, e.g., establishment of clearer and more rigorous criteria regarding what constitutes an appropriate traineeship experience
- Too focused on private practice side of the world. Not doing a very good job of helping students to identify their own stigma I fear with respect to clients
- The educational system has not caught up with the System of Care Best Practice Principles that are the backbone of solid and effective care in the public mental health system
- Clinicians straight out of school are not prepared for the business mission of their work that operates in concert with the social mission
- Many programs for future MFTs are focused on the “hang your shingle” mentality toward private practice, not fulfillment (and yes even financial benefits) of choosing a career in public mental health, but during graduate program are only provided opportunities that will reflect their financial success in private practice, leaving many to feel that as public servants they will not become rich or have flexibility
- Very little understanding or familiarity with the needed competencies
- Clinicians/facilitators coming into the workforce directly out of school are unprepared for the work world. They are often lacking community preparedness-not having the necessary skills (understanding of risk, safety issues, ect.) to work within the community and to provide services within the community. Many clinicians are trained for an office environment and are, thus, lacking necessary skills to provide mental health services within homes and other community venues
- Most are not prepared for the paperwork required for public mental health and are very disappointed
- Paperwork requirements
- Time management
- Client population

ATTACHMENT B

- Many interns lack skills needed to write coherently, including basic grammar and punctuation.
- Most are unfamiliar with a basic mental status exam and do not know what it means to be oriented(or not) in 3 or 4 spheres
- MFT education too focused on traditional, office-based “50 minute hour” psychotherapy need practitioners comfortable working in-home and in-community with multiple systems
- We have had some very qualified applicants but they have required training in how to provide community-based mental health treatment. They have not had enough training in what it is like to work in the community
- As best as it can, there is no substitute for traineeships, internships and on the job experience
- Most programs do an adequate job in addressing basic skills, but courses are often geared toward providing services within the private sector. There should be more of a focus on public mental health systems and services that benefit the chronic/seriously mentally ill (public sector focal populations). Offering courses in goal setting, treatment planning, and note writing are lacking as well and are a requisite skill in working in the public sector
- It really depends on the graduate program. We are finding that some graduate programs do a better job of preparing their students for the current workforce: whereas others do not. Primarily we are finding some programs do not provide enough clinical training or helping staff document, ect.
- No for older adults
- Interns who have clinical training at CBO's have little interest in working in the community
- Schools don't prepare interns for “life” outside of grad schools
- Little attention to older adults
- Not interested in working in public sector

ITEM C: What are the most important skills/knowledge/experience necessary for a candidate to be job-ready for your agency?

- Understand the demands of a DMH contract agency
- Knowledge of the various ethnic populations in the area
- The cultural and linguistic characteristics of the populations of concern
- Ability to engage with people that may not be from the same background as the provider
- Ability to document services in clinical charts
- Willingness to meet and provide services to clients in their natural settings, including their home, community setting, such as the church, school, ETC
- Recovery is possible
- Intergraded Mental Health and substance use treatment
- What serious mental illnesses are, symptoms, intervention strategies
- Substance use training
- Working in a partnership w/ consumers and families engagement skills
- Documentation skills
- Good judgment and intrapersonal skills
- Knowledge of best practices

ATTACHMENT B

- Prepared for community based practice and environment
- Solid training and experience in providing therapeutic services in individual, family, and group modalities
- Ability to make appropriate diagnoses and then use these diagnoses in the development of treatment plans and the implementation of service delivery
- Sensitivity to cultural and individual diversity factors which impact treatment and the therapeutic relationship
- Ability to write clear, concise progress notes and reports, and to do so in a manner that meets agency deadline expectations
- Ability to work effectively as a member of a interdisciplinary team
- Not to be scared of those they will serve
- Know how to establish trusting relationships
- Be hopeful
- Basic and intermediate level counseling skills
- Engagement and joining skills
- Expert level communication skills
- Intermediate level clinical documentation skills
- Exposure to evidence based practices, outcome and evaluation
- Thorough training in best practices principles
- Clinical Skills- rapport building, therapeutic alliance, differential diagnosis, appropriate intervention driven by and tailored to the individual and family
- Good writing, communication and organizational skills
- Cultural awareness and competency beyond basics
- Open-mindedness, sense of humor
- Everything they are currently learning at school, with the addition of a better understanding of how the entire therapeutic process flows together. Also, more experience developing a service plan which addresses case management and support services.
- Additional competencies including Writing skills, Community preparedness, Clinical skills. Documentation skills, Some knowledge of the massive amount of paperwork requirements, Diagnosis/ assessment,
- Understanding Family dynamics; Treatment modalities; Understanding theory of solution focused, brief strategic cognitive behavior; Understanding substance abuse; Knowledge of Family Systems Theory
- Experience, willingness and ability to work with families
- Ability to work with families with multi-layered problems, i.e. substance abuse, poverty, domestic violence, single parents, blended families, ect.
- Fluent Spanish speaking
- Skills to work in-home with complex systems
- Ability and willingness to do quality charting of client services
- Understanding of the needs of outpatient mental health clients,
- Willingness to be flexible in their approach and not tied to a “private practice” model of treatment
- Willingness to work in the community at school sites, clients’ homes or other community sites
- Ability to accept feedback and be thoughtful about the interventions that they make with clients
- Competencies in trauma, mental illness, assessments and diagnosis, treatment planning, social recovery

ATTACHMENT B

- Previous experience with the population, enthusiasm, a desire to learn, flexibility, clean background check and excellent references
- Assessment and diagnosis, treatment planning/goal setting, skills-building/behavioral interventions, and psychopharmacology
- Understanding legal and ethical issues related to providing clinical services
- The ability to assess and intervene in a clinical crisis
- Basic clinical understanding
- Ability to document work at all levels – assessment, progress notes, discharge, etc.
- Computer literate
- Ability to recognize and work through counter transference issues: sustain healthy boundaries
- Willingness and interest in working with older adults
- Understanding of issues related to aging such as loss, frailty, medical and bio-psychosocial issues
- Looking at the person as a “whole” and not treating the diagnosis or finding someone to be resistant to treatment without understanding who this person is, where, and how they live, etc.
- Ability to work with an older adult in the “here and now” in order to help them, practical and short term intervention
- Willingness to make home visits or treat someone at home and understand boundaries and providing services at home
- Working with vulnerable and sometimes “undesirable” populations like homeless, or the more chronic type of client
- Be ready and willing to be a part of an interdisciplinary team with other professions

ITEM D: What are the skills/knowledge/attitudes that are most effectively developed on the job at your worksite?

- Integrated dual diagnosis treatment
- **How our agency culture works (mentioned many times)**
- Emergency protocols, crisis interventions, referral services and case management. Hands on experience treating clients and observations by way of one way mirror teams
- Skills of other disciplines
- Teamwork within our culture
- Specific documentation beyond MediCal
- Trauma focused cognitive behavior training
- Case management and community resources within our county
- Understanding of community mental health agencies, collaborating/partnering with other agencies
- Teamwork within a multidisciplinary team, systems/community approaches to treatment and specific approaches to treatment (e.g., culturally specific approaches)
- Understanding of psychotropic meds, treatment planning, outcome measurements, system integration, respect for the struggle our clients have, use of supervision, team approach to treatment, electronic charting
- County specific Medi-Cal documentation requirements

ATTACHMENT B

- Time management
- Assessment skills/tools including the use of a genogram, family map, county specific psychometrics
- Specific issues related to working with a particular population
- Community resources
- Collaborations with other agencies and partners
- Clinical mastery
- **Documentation requirements**, billing procedures, entitlement benefits
- Community education
- Utilizing resources within the community
- Working in teams/group settings
- Exposure to and utilization of evidence based practices
- Knowledge of local community and population
- Case documentation (e.g., agency expectations regarding progress note content)
- Keeping up with the ever changing requirements and expectations of the County Dept. of Mental Health
- Awareness of specific resources and services in the community
- Specific information related to entitlements/benefits community supports
- Skills related to the specific program contract/treatment requirements
- Agency core values
- Specific documentation requirements
- Local resources
- Consumer and family engagement
- Strength based services
- Focus on recovery and resilience
- Cultural sensitivity
- Application of evidence/excellence based practices
- Refinement of clinical documentation
- Specialty populations – 0 – 5, integrated substance abuse/mental health services, trauma-related services, and older adults
- Field based services
- Team collaboration
- Crisis intervention
- Community resources
- Time management
- Treatment planning and evaluation
- The course of mental illness
- Medications
- Effective clinical interventions
- Specific skills or knowledge might be related to the more concrete services/resources needed by older adults, but if the clinician feels that this is “not a part of their job” then I would not even consider them for a position at my organization. Compartmentalizing a client and only treating a particular diagnosis would not be acceptable
- Charting, service planning, accessing community resources
- Local Medi-Cal billing structure, policies and procedures
- Self-reflection

ATTACHMENT B

- Documentation (specifically content, writing style and use of clinical language should be addressed elsewhere)
- Delegation of responsibilities to other team members
- Systems orientation
- Agency mission and vision and ability to incorporate into daily work ethic
- Specific agency documentation standards and expectations
- Ability and willingness to be flexible in utilizing various modes of treatment – client driven and tailored to the consumer
- Self care techniques and ways to seek support from various means (peers, supervisor, outside interests)
- Leadership skills

ITEM E: Would it influence your hiring decision if a candidate held a specialty certificate in Public Mental Health offered by a professional association or private business? (You may check more than one).

The majority of responses selected the following two choices:

- Our hiring decisions are based on a diversity of factors beyond prior coursework or external indicators of competency.
- With adequate changes in the educational curriculum, we would also prefer to have available CEU opportunities to continue developing and improving skills needed in the public sector.

ITEM F: Would the requirement or options to have a special certificate for serving the public sector contribute to or add barriers to the availability to an adequately trained workforce for public sector agencies? ☐ Contribute ☐ Add Barriers ☐ Undecided

The majority of responses indicated that a certificate would either add barriers or that they were undecided about the potential impact.

Comments:

- It is difficult for me to comment because I would need to know what the students are learning differently in a certificated program. It might influence our hiring decisions if the program provided the candidate with special or particular skills related to working in a community mental health setting.
- It would contribute if a crosscutting certificate program allowed those with BAs to do more clinical work. In my experience as a manager, I've had team members who could not provide certain types of service even though their experience and intuition made them more effective clinicians than others who had graduate degrees.
- A more important factor in transforming the system is making a strong effort to change the overall profile of those entering the profession. Individuals from minority populations, consumers of mental health services, and people who really want to work with this population.

Attachment C

TURNING POINT COMMUNITY PROGRAMS JOB DESCRIPTION

JOB TITLE: FAMILY COORDINATOR

REPORTS TO: Program Director

LOCATION: Children's Services

APPROVED BY: John Buck, Executive Director

DATE:

SUMMARY: Responsible for the treatment plan and development based on the strengths and expressed needs of the child and his or her parents.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may also be assigned:

- * Works in partnership with parents who are treated as experts concerning their families.
- * Completes intake paperwork.
- * Conducts strength/needs assessment.
- * Organizes child and family team.
- * Facilitates the child and family team meeting, guiding the team through a review of the family strengths, through a needs assessment by life domain, and through problem solving and plan of action identification. The family coordinator is responsible for facilitating the team meeting in such a way as to give parents the primary role in deciding what needs are priorities and what courses of action are best for their child and their family.
- * Responsible for recording and implementing plan of action.
- * Responsible for implementing time performance outcome evaluations and for involving parents in the process.
- * Responsible for coordination of services with outside agencies.
- * With the director input from the child and family, enlists the involvement of formal and informal community resources to support the family.
- * Responsible for coordinating TX with Family Support Worker.
- * Sees the family weekly for periods of time/days that may vary depending on the need of the family.
- * Discharge planning/transitional service development.
- * Responsible for all required record keeping as indicated by county and agency.
- * Safely transports clients and other passengers to and from appointments and activities using own personal vehicle.

- * Provides prompt intervention in the event of a crisis both to stop the crisis and to notify when indicated, persons and agencies necessary for the resolution of the crisis situation.
- * Provides "on-the-spot" counseling that is both helpful to the clients and consistent with the philosophy of the program.
- * Attends to the safety, health, and well-being of clients.
- * Completes paperwork as assigned in a timely manner.
- * Is personally responsible and held accountable for work hours and time management as coordinated with the Program Director.
- * Provides support to other staff members as needed.
- * Enforces the policies and procedures of Turning Point Community Programs.
- * Attends all team and agency staff meetings unless approval for non-attendance is secured by the Program Director.
- * Attends Family Natural Team Meeting as indicated
- * Attends Child and Family team meetings as indicated
- * Knowledge of and commitment to principles and goals of "family centered model".
- * Commitment to wrap around approach when working with families.

QUALIFICATION REQUIREMENTS: To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION AND/OR EXPERIENCE:

Graduation from a four year college or university with a Masters degree in Social Work, Psychology, or related field. License-eligible or license waived. Experience working with high-need children and families.

LANGUAGE SKILLS:

- * Ability to communicate effectively orally and in writing.

CERTIFICATES, LICENSES, REGISTRATIONS:

- * Valid California driver's license, current vehicle insurance and driving record acceptable to Turning Point's vehicle insurance company and the Vehicle Driving and Maintenance Policy.
- * Possesses and maintains a safe and reliable form of vehicular transportation excluding motorcycles.

OTHER SKILLS AND ABILITIES:

- * Knowledge of community services.
- * Ability to establish rapport with high-need children and families.
- * Ability to view parents as partners and "experts" in the assessment and planning for their child and family.
- * Willingness to be flexible around the needs of the family.

- * Embraces a strength based/needs assessment approach to helping high-need families and their children.
- * Ability to work and communicate with staff, ISA members, families, community agencies and professionals.
- * Ability to perform crisis intervention strategies.
- * Ability to work effectively under stress and conflict.
- * Ability to exercise appropriate judgment and decision-making.
- * Ability to be flexible and adaptable in any given situation.
- * Ability to work as a member of a team.
- * Ability to work under time deadlines and pressures.
- * Ability to work with minimal supervision.
- * Knowledge of and commitment to principles and goals of community mental health.
- * Knowledge of and commitment to principles and goals of the "self-help model".
- * Knowledge of and commitment to principles and goals of the "consumer-driven model".
- * Knowledge of psychosocial rehabilitation's treatment and programming.

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is required to walk, stand, and use the hands. Occasionally, the employee must crouch or kneel. The employee must exert or lift up to 25 pounds.

WORK ENVIRONMENT: The work environment conditions described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

There are no unusual conditions. Typically the noise level in the work environment is moderate.

STATEMENT:

I have read and understand the job description for Family Coordinator.

Employee

Date

Bill Wilson Center Job Description

Job Title: Clinical Therapist
Department: Counseling Center/Bill Wilson House
Reports To: Director of Counseling
FLSA Status: Exempt
Prepared By: Director of Administration
Prepared Date: February 17, 1997
Approved By: Executive Director
Approved Date: February 20, 1997
Salary Range: \$48,510 - \$54,810 annually plus full benefits

SUMMARY

Counsels individuals or groups regarding psychological or emotional problems such as stress, substance abuse, or family situations and develops and implements therapeutic treatment plan by performing the following duties. Some evening and/or weekend working hours required.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned.

Interviews patient to obtain information concerning medical history or other pertinent information.

Observes client to detect indications of abnormal physical or mental behavior.

Selects and administers various tests such as psychological tests, personality inventories, and intelligence quotient tests, to identify behavioral or personality traits and intelligence levels, and records results.

Reviews results of tests to evaluate client needs.

Plans and administers therapeutic treatment such as behavior modification and stress management therapy to assist patient in controlling disorders and other problems.

Changes method and degree of therapy when indicated by client reactions.

Discusses progress toward goals with client such as controlling weight, stress, or substance abuse.

Consults with medical doctor or other specialists concerning treatment plan and amends plan as directed.

Conducts relaxation exercises, peer counseling groups, and family counseling during clinical therapy sessions.

Refers client to supportive services to supplement treatment and counseling.

Conducts research in treatment and test validation.

Develops evaluative studies of therapy and therapy outcome.

Maintain an appropriate case load of adolescents, families, and groups with responsibility for completing all work/documentation to accomplish this task.

Handle crisis phone calls and walk-in crisis situations.

Under supervision of Clinical Director co-train and supervise 8 to 10 interns. Includes one hour of individual supervision and co-therapy.

Conducts workshops as assigned.

SUPERVISORY RESPONSIBILITIES

This job has no direct supervisory responsibilities.

QUALIFICATIONS To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION and/or EXPERIENCE

Master's degree (M. A.) or equivalent; or four to ten years related experience and/or training; or equivalent combination of education and experience.

LANGUAGE SKILLS

Ability to read, analyze, and interpret common scientific and technical journals, financial reports, and legal documents. Ability to respond to common inquiries or complaints from customers, regulatory agencies, or members of the business community. Ability to write speeches and articles for publication that conform to prescribed style and format. Ability to effectively present information to top management, public groups, and/or boards of directors. Bilingual in Spanish and/or Asian dialects strongly preferred.

MATHEMATICAL SKILLS

Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and to draw and interpret bar graphs.

REASONING ABILITY

Ability to apply principles of logical or scientific thinking to a wide range of intellectual and practical problems. Ability to deal with nonverbal symbolism (formulas, scientific equations, graphs, musical notes, etc.,) in its most difficult phases. Ability to deal with a variety of abstract and concrete variables.

CERTIFICATES, LICENSES, REGISTRATIONS

Marriage & Family Counseling or Licensed Social Worker license required.

PHYSICAL DEMANDS The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to sit; use hands to finger, handle, or feel; reach with hands and arms; talk or hear; and taste or smell. The employee is occasionally required to stand and walk. The employee must occasionally lift and/or move up to 10 pounds. Specific vision abilities required by this job include close vision, color vision, peripheral vision, depth perception, and ability to adjust focus.

WORK ENVIRONMENT The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually moderate.

EEO

Bill Wilson Center is an Equal Opportunity/Affirmative Action Employer.



Foothill Family Service – Job Description

Job Title: Therapist, Licensed
Department: Clinical Services
Reports To: Clinical Supervisor
FLSA Status: Exempt
Job Code: 2
Revision Date: 5/3/2005

SUMMARY

Therapists are clinicians who have received their Masters degree in an accredited counseling program and are licensed in the state of California as an MFT, LCSW or a licensed Psychologist.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned.

Supports and promotes the mission of the agency: Building Brighter Futures for Children and Families.

Carries caseload of which will possibly include individual therapy, play therapy, sexual abuse treatment, child abuse treatment, group therapy, EAP treatment, crisis intervention, school based services and in-home treatment. Meets productivity standards as set by department.

Attends mandatory meetings such as child abuse treatment meeting and school based counseling meeting.

Assists intake, reception, clinical staff and accounting in the collection of complete and accurate information necessary for treatment and billing.

Completes all client forms for intake assessment, on-going progress notes and treatment plans and updates.

Follows agency billing procedures by providing accurate information, working in concert with accounting and maintaining a clinical relationship with clients.

Effectively represents the agency at community meetings, provides inservice training to other agencies, consults with other agencies and schools, represents the agency at marketing events and professionals from other agencies.

Provides telephone counseling for emergencies both during office hours and outside of office hours for own clients and other agency clients.



Relates harmoniously with staff and clients of diverse backgrounds. Demonstrates knowledge and sensitivity to cultural differences.

Supports agency policies, the smooth functioning and communication within the agency. Works effectively and cooperatively with other agency staff, collaborating when appropriate.

Works in close harmony with the Director of Clinical Services and their Clinical Supervisor, accepting direction and implementing policies and procedures reflective of this direction.

Ability to comprehend and follow both complex oral and written instructions.

Follows all agency guidelines on confidentiality, reporting of child abuse and neglect, and recording in case records.

Works closely with their supervisor and/or the Director of Clinical Services, discussing cases, submitting any required process recordings and/or audio or video recordings, and accepting the supervisory process.

May require the ability to drive and make visits to program sites away from the main office.

Follows all the legal mandates of HIPAA for client confidentiality and release of information.

Performs other duties as assigned.

Performance Standards

1. Consistently meets performance standards as set by department.
2. Completes all required documentation for client files and billing.
3. Majority of caseload meets treatment goals.

SUPERVISORY RESPONSIBILITIES

This job has no supervisory responsibilities.

QUALIFICATIONS To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable



accommodations may be made to enable individuals with disabilities to perform the essential functions.

Experience in providing direct service to individuals, families and groups. Experience in providing child abuse treatment. Experience in providing treatment to children with serious emotional problems.

Ability to be an excellent representative of the agency to the community.

Excellent written and oral communication skills and the ability to read and write complex material.

Ability to effectively use of DSM IV.

Good interpersonal skills, including the ability to work cooperatively as a team member.

Knowledge and sensitivity to cultural differences.

Ability to relate harmoniously with staff and clients of diverse ethnic and economic backgrounds.

Possess a safe driving record.

Ability to drive a car that can carry more than 2 passengers.

EDUCATION and/or EXPERIENCE

Masters degree from accredited social work, marriage and family therapy, or psychology program.

Licensed in the state of California: LCSW, MFT or Licensed Psychologist

LANGUAGE SKILLS AND REASONING ABILITY

Ability to make sound clinical judgements and follow and give complex directions.

Ability to read and interpret documents such as assessments, journal articles and procedure manuals.

Ability to write routine reports and correspondence. Ability to speak effectively before groups of clients or employees of organization.

Ability to define problems, collect data, establish facts, and draw valid conclusions. Ability to interpret an extensive variety of technical instructions and deal with several abstract and concrete variables.

**MATHEMATICAL SKILLS**

Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and to draw and interpret bar graphs.

OTHER SKILLS AND ABILITIES

Some positions require bilingual skills in Spanish, Cantonese/Mandarin, Korean, or Armenian.

CERTIFICATES, LICENSES, REGISTRATIONS

Clinical Licensure as LCSW, MFCC or Psychologist
Valid CA Driver License

PHYSICAL DEMANDS The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to talk or hear. The employee frequently is required to sit and use hands to finger, handle, or feel. The employee is occasionally required to stand; walk; reach with hands and arms; and stoop, kneel, crouch, or crawl. The employee must occasionally lift and/or move up to 25 pounds. Specific vision abilities required by this job include close vision, and ability to adjust focus. Some positions require driving and specific vision abilities required by this that include, distance vision, peripheral vision, depth perception.

WORK ENVIRONMENT The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually moderate. Some positions may also require that the employee occasionally be exposed to outside weather conditions.



☑
Administrative Office
6333 Telegraph Avenue, Suite 102
Oakland, CA 94609-1328
(510) 923-1099
(510) 923-0894 Fax
(510) 923-0969 TDD

☐
Dual Diagnosis
Residential Program
1410 Bonita Avenue
Berkeley, CA 94709-1909
(510) 526-4765
(510) 526-2887 Fax

☐
Supported Independent
Living Program
Transitional Housing
Permanent Housing
Case Management
6333 Telegraph Avenue, Suite 102
Oakland, CA 94609-1328
(510) 923-0180
(510) 923-0894 Fax

☐
Berkeley Creative
Living Center
PO Box 4519
Berkeley, CA 94704-0519
(510) 548-2269
(510) 548-2271 Fax

JOB ANNOUNCEMENT

Program: Bonita House HOST Program
Position: Supervising Psychiatric Social Worker
Responsible to: Program Director

Salary and Conditions: Starting Salary for 1 FTE / \$60,000. a year. This is a full-time, 40 hours per week, exempt position.

Benefits: Fringe benefits include: medical, dental, chiropractic and acupuncture plans, life insurance, long-term disability insurance, tax deferred annuity plan, dependent care assistance program (DCAP), credit union, retirement plan, educational assistance plan, legal services program, and an excellent paid time off package.

Posting Date: October 9, 2006

Application deadline: Open until filled.

Bonita House, Inc. is a non-profit social rehabilitation agency providing a full range of services to adults diagnosed with both serious psychiatric disabilities and co-existing substance use disorders. Bonita House, Inc. administers Integrated Dual Diagnosis Treatment site and field based programs at eight locations throughout Alameda County. BHI prides itself on providing clients with evidence-based practices promoting dual-recovery in a client-driven system.

Program Summary: HOST (Homeless Outreach and Stabilization Team) is a new Assertive Community Treatment (ACT) program created through the Mental Health Services Act (Proposition 63) to actively outreach, engage, house, and provide a full range of services to 90 adults in northern Alameda County who are homeless and have serious psychiatric disorders.

Services will be predominately field-based rather than office-based, and will provide integrated substance abuse and mental health treatment. Key features are the voluntary nature of the services, the partnership with clients and families, service intensity, 24/7 coverage, the foundation of wellness and recovery principles and practices, and the commitment to do "whatever it takes", utilizing the creativity of a multi-disciplinary, full team approach.

Position Summary: This position will assist in providing clinical support and oversight to HOST Personal Service Coordinators, and provide supervisory assistance to the Program Director. S/he will serve as the mental health specialist on the team. The ideal candidate will be familiar and comfortable with homeless individuals and street culture and will demonstrate an ability to establish trusting, hopeful relationships with these individuals.

Duties and Responsibilities:

1. Outreach, engage and provide respectful, recovery-based services to adults with histories of chronic homelessness, serious psychiatric disabilities and co-occurring substance use disorders.
2. Assist the Program Director in the orientation, training, and clinical supervision of other HOST staff as well as managerial responsibility for the program.
3. Assumes responsibilities for Program Director in his or her absence.
4. Provide service coordination (case management) for HOST clients including coordinating and monitoring the activities of the treatment team; assume responsibility for developing, writing, implementing, evaluating and revising overall treatment goals and plans in collaboration with the clients, families, and the HOST team.
5. Provide and assist in training other staff in trauma-informed, Integrated Dual Diagnosis Treatment services.

6. Provide individual, group and family therapy, motivational enhancement, stage-based interventions, and wellness management, ensuring immediate changes are made in the treatment plans as clients' needs change.
7. Educate and support clients' families and advocate for clients' rights and preferences.
8. Provide psychoeducation about mental illness, dual diagnosis and recovery to clients and families.
9. Conduct strength-based, culturally informed, comprehensive, integrated mental health and substance use assessments.
10. Take a lead role or participate in the provisions of rehabilitation services.
11. Liaison with community agencies and families to maintain coordination in the treatment process.
12. Provide on-call crisis intervention covering nighttime and week-end hours on a rotating basis. Serve as a backup to HOST staff in crisis situations as needed.
13. Maintain all documentation standards per agency and regulatory requirements.
14. Assess, assist and coach clients in activities of daily living to maintain housing stability and achieve clients' goals.
15. Provide benefits counseling (e.g., Supplemental Security Income [SSI], veterans' benefits).
16. Organize and lead individual and group social and recreational activities to structure clients' time, increase social experiences and provide opportunities to practice social skills and receive feedback and support.
17. Provide risk assessment of clients. Ensure immediate and appropriate interventions are provided in response to changes in mental status or behavior which put clients at risk (e.g., suicidality).
18. Coordinate with outside inpatient services to detoxify clients and establish linkage to outpatient treatment, self-help programs (e.g., Alcoholics Anonymous, Narcotics Anonymous, Dual Recovery Anonymous, WRAP Trainings and Groups), outpatient services and residential facilities.
19. All other duties as assigned by supervisor.

Minimum Qualifications:

- Master's degree in social work, psychology, or a related field plus licensure as an LCSW, MFT, or Ph.D. and five years experience in substance abuse treatment or mental health treatment or related social service experience.
- Clinical skills and experience to assess, plan, develop, coordinate and provide treatment, rehabilitation and support services to HOST clients with histories of homelessness, severe and persistent mental illnesses and co-occurring serious substance use disorders.
- Strong commitment to the right and ability of each person with a severe and persistent mental illness to live in normal community residences; work in market jobs; and have access to helpful, adequate, competent and continuous support and services.
- Skills and competence to establish supportive, trusting, respectful relationships with persons with histories of homelessness, severe and persistent mental illnesses and co-occurring serious substance use disorders.
- Demonstrated ability to effectively and sensitively provide care to people from different cultural groups.
- Must be able to communicate effectively both orally and in writing.
- Must be able to meet Immigration Reform Act of 1986 requirements.
- Must have a valid California Driver's License, proof of insurance and use of personal automobile.

How to apply:

Mail/Fax/Email resume and cover letter detailing related experience to:

Bonita House, Inc.
6333 Telegraph Avenue, #102
Oakland, CA 94609
FAX 510-923-0894

Email: resumes@bonitahouse.org (please include resume in the body of your email, attachments will not be accepted.) Appropriate candidates will be contacted.

Bonita House, Inc. is a non-profit community agency, and an equal opportunity employer by choice. We value diversity of culture, disability, and other life experiences, and invite applications from those in mental health and/or chemical dependency recovery.

Bonita House, Inc. is a CAADE/CADAAC Training Provider and can provide CAADE/CADAAC supervision hours.

This position is subject to approval of the Alameda County Board of Supervisors on 10/31/06.

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ALTERNATIVE FAMILY SERVICES JOB DESCRIPTION

JOB TITLE: ASSISTANT MENTAL HEALTH DIRECTOR

REPORTS TO: ASSOCIATE DIRECTOR

EXEMPT/NON-EXEMPT: EXEMPT

SUMMARY: The Assistant Mental Health Director has the responsibility for assisting the Mental Health Director in overseeing the clinical and Quality Improvement aspects of all of Medi-Cal funded programs in the Agency (i.e., teen emancipation, post-adoption support, and therapeutic visitation/reunification). He/She will directly supervise specifically-assigned staff members in the areas of social work, case management, quality improvement, and billing and will serve the role as a Working Clinical Director. The Assistant Mental Health Director will assist as needed in the development, implementation, and evaluation of casework, intake, staff development, and all Medi-Cal services to children and families within the agency. The Assistant Mental Health Director has a solid understanding of case management and family systems and a registered or licensed clinician who has experience in administrative management within public social service, mental health, or managed care systems that serve youth. The Assistant Director will also carry a partial case load of clients and provide direct services (see Permanency Worker Job Description for those duties).

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned.

1. Quality of Clinical Services
 - a. Responsible for the Quality Improvement aspects of the program including knowing rules and regulations and implementing procedures to assure compliance with Medi-Cal and other regulations.
 - b. Responsible for the Clinical Direction of the program including signing progress notes and treatment plans and assuring that services provided are appropriate given client need. Assistant Director will work with staff to improve writing and documentation skills as needed.
 - c. Responsible for working part-time as a Permanency Worker, carrying a small caseload, and taking over cases when another worker is has been terminated, is on vacation, or is in any other way not available.
 - d. Assists, as directed by the Mental Health Director, in the overall operation and services delivered by the program including the development, implementation and evaluation of all mental health programs, staff training programs, intake, casework, educational and vocational resources, and coordination with outside agencies.
2. Program Supervision
 - a. Responsible for direct supervision of specific Permanency Workers and will meet with them on weekly basis.
 - b. Will directly supervise Quality Improvement/Billing personnel and meet with them on a weekly basis.
 - c. Conducts weekly treatment team meetings and administrative staff meetings as directed.
 - d. Supervises middle management and program directors in methods consistent with the agencies treatment philosophy and approach.
3. Personnel Supervision
 - a. Provides individual weekly supervision of staff, which includes budget management and personnel issues.
 - b. Writes staff evaluations in a timely manner.
 - c. Participates in hiring, termination, and discipline of the program staff as dictated by the agency's personnel policy.
 - d. Responsible for staff scheduling and program coverage
4. Community Representation
 - a. Represents the agency in the community at large.
 - b. Serves as an agency representative to community resources.
5. Administrative.
 - a. Responsible for assuring timely submission and oversight of monthly invoices to Accounting Department for billing to county behavioral health departments.
 - b. Responsible to oversee all program record keeping, time sheets, mileage, incident reports, etc.
6. Assumes other duties as assigned by the supervisor.

(This job description is not a contract for work. It is a management tool for assigning responsibilities.)

JOB DESCRIPTION

JOB TITLE: CLINICIAN - SOCIAL WORKER
DAY TREATMENT

STATUS: AT-WILL/EXEMPT

STATEMENT OF THE JOB

As a member of the /day treatment team, the Clinician is responsible for establishing and implementing quality clinical treatment and case management for severely emotionally disturbed children and adolescents in the day treatment programs.

DAILY RESPONSIBILITIES

1. On a daily basis, completes an ongoing assessment to identify the changing social/behavioral needs of the client(s) and the subsequent development of necessary plans to address those needs.
2. Counseling with assigned clients aimed at preparing the client to analyze and better understand the reason for placement and to handle associated emotional problems, resolving the difficulties that led to the need for placement, and planning for the return of the child to lower level of placement.
3. Act as the liaison between the program and community agencies and individuals and attend planning conferences as required including IEP, ITP, Case Conferences.
4. The clinician shall develop a service plan based on a comprehensive assessment of each client's personal milestones and obstacles, and shall evaluate each clients progress and adjust the service plan as may be necessary and appropriate.
5. The clinician shall develop appropriate documentation in a timely manner for each assigned client and maintain a comprehensive set of treatment records on each client as stipulated in Day Treatment Intensive Regulations.
6. The clinician shall consult with collaterals regarding implementation of service plans in the Intensive Day Treatment and residential setting.
7. Supervise the day intensive activities.

(A Victor Treatment Centers, Inc. Personnel Form)

Approved By: _____ Chief Executive Officer – Issue Date: 06/02/05

8. Follow all pertinent guidelines of the County Quality Improvement Plan as it applies to the function of the Clinical position.
9. Other functions appropriate to the professional expectations of a licensed mental health professional.

ESSENTIAL REQUIREMENTS

1. Completion of a clinical program with Masters or Ph.D. degree in a field of behavioral science from an accredited educational institutional.
2. Needs to be eligible for licensure and hold a clinical license issued by appropriate state agency consistent with standards outlined in the Agency's Clinical Staff Licensing Requirements policy.
3. Must possess a valid California driver's license, and driving record that meets the standards outlined in the Agency's Personnel Policy; Motor Vehicle Operating Standards. Must possess personal automobile insurance consistent with the standard outlined in the Agency's Personnel Policy; Motor Vehicle Operating Standards.
4. Must be physically and mentally fit to work with potentially violent, severely emotionally disturbed adolescents in accordance with the Agency's personnel Policy: Physical and Mental Fitness Standards; must be willing to complete a health screening physical examination that includes a drug screen and a back screen; and must have the unrestricted capacity to employee physical restraint techniques in a professionally safe manner.
5. Must be willing to complete a personal background investigation conducted by the State of California; and must meet Community Care Licensing standards for employment.
6. Must obtain a First Aid Certification and CPR Certification.
7. Must be willing to work within a culturally integrated workplace, and be willing to respect human differences based on race, age, handicap, religion, sexual orientation, political persuasion, place of origin, color, or any other condition that distinguishes people from one another.
8. Must be able to interact and communicate in a timely, friendly and cooperative manner with other professionals working within the mental health /education industry both in public and private agencies while traveling, meeting, presenting, participating in workshops and training sessions, or performing clinical services pertaining to the Agency's clients.

9. Requires the ability to think and act quickly in emergencies; effectively deal with personal danger; maintain mental capacity which allows the capability of exercising sound judgment and rational thinking under varied circumstances. Must be able to work safely with seriously emotionally disturbed children who may become violent, and physically and verbally offensive, without reacting in a negative, cruel or hostile manner towards the client.

DESIRED REQUIREMENTS

1. Two years experience in a clinical position in residential treatment.
2. Experience with severely emotionally disturbed children or adolescents.
3. Current First Aid and CPR Certification.

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Agenda Item VII:

Discussion of Draft Revisions to
Curriculum Statutes

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**State of California
Board of Behavioral Sciences**

Memorandum

To: MFT Education Committee

Date: February 28, 2007

From: Paul Riches
Executive Officer

Telephone: (916) 574-7840

Subject: **Concept Draft for Curriculum**

Attached to this memo is a "concept draft" of curriculum requirements for marriage and family therapists.

In summary, comments indicate that there is much of the current curriculum requirements that remains useful and meaningful to public practice, but that some added material is needed. However, the most significant changes focus on transmitting the culture and norms of public mental health work and principles of the Mental Health Services Act (including recovery, resiliency, consumer empowerment and participation, evidence based practice, etc.) that need to be infused throughout the curriculum to show how the core skills and knowledge imparted by the current curriculum apply. The committee has also heard repeated calls from educators for more flexibility in the curriculum requirements to allow innovation in curriculum design.

The attached concept draft is intended a document to stimulate discussion and begin to bring the committee's deliberation to the point of suggesting concrete revisions. The draft is mostly a restructuring of current requirements, but it does include several major changes that merit highlighting:

- The requirement to integrate principles of recovery throughout the curriculum (b)(2)
- Inclusion of a number of particular additional areas to be covered (Case management, Systems of care for the mentally ill, Professional writing including documentation of services, treatment plans, and progress notes, Public and private services and supports available for the mentally ill, Community resources for victims of abuse). The added courses could be satisfied by extension or credit level courses offered by the degree granting institution.

A remaining area that has not been meaningfully addressed at this point are requirements on substance abuse training to make sure that it reflects current thinking and practice in the area.

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Concept Draft for MFT Curriculum

§4980.37. DEGREE PROGRAM

(a) Applicants shall possess a doctor's or master's degree conferred by a school, college or university accredited by the Western Association of Schools and Colleges, Commission on the Accreditation of Marriage and Family Therapy Education, or approved by the Bureau for Private Postsecondary and Vocational Education¹ in one of the following disciplines:

- (1) marriage, family, and child counseling,
- (2) marital and family therapy,
- (3) psychology,
- (4) clinical psychology,
- (5) counseling psychology,
- (6) counseling with an emphasis in marriage, family, and child counseling, or
- (7) counseling with an emphasis in marriage and family therapy.

(b) A qualifying doctor's or master's degree shall:

- (1) Integrate marriage and family therapy principles throughout its curriculum.
- (2) Integrate the principles of recovery and resilience throughout its curriculum.
- (3) Allow for innovation and individuality in the education of marriage and family therapists.
- (4) Encourage students to develop those personal qualities that are intimately related to effective practice such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.
- (5) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.
- (6) Integrate the understanding of various cultures and the social and psychological implications of socio-economic position throughout its curriculum.
- (7) Encourage students to meet with various consumers of mental health services so as to understand their experience of mental illness.

(c) In order to qualify for licensure, a doctor's or master's degree program shall contain no less than 48 semester or 72 quarter units of instruction that includes, but is not limited to:

- (1) Diagnosis, assessment, prognosis and treatment of mental disorders including psychological testing.
- (2) At least 12 semester or 18 quarter units in theories, principles, and methods of a variety of psychotherapeutic orientations directly related to marriage and family therapy, and marital and family systems approaches to treatment and how these theories can be applied therapeutically with individuals, couples, families, adults, children, and groups to improve, restore, or maintain healthy relationships.
- (3) Developmental issues from infancy to old age. This instruction shall include:
 - (A) The effects of developmental issues on individuals, couples, and family relationships.

¹ This will be changed to reflect whatever is the final outcome regarding reform of the BPPVE and recent board actions to sponsor legislation recognizing regional accreditation agencies.

- (B) The psychological, psychotherapeutic, and health implications of developmental issues and their effects.
 - (C) Aging and its biological, social, cognitive, and psychological aspects.
 - (D) A variety of cultural understandings of human development.
- (4) The broad range of matters that may arise within marriage and family relationships and life events within a variety of California cultures including:
- (A) Child abuse assessment and reporting
 - (B) Spousal or partner abuse assessment, detection, intervention strategies, and same gender abuse dynamics
 - (C) Cultural factors relevant to abuse of partners and family members.
 - (D) Childbirth
 - (E) Child rearing, parenting and stepparenting,
 - (F) Marriage
 - (G) Divorce
 - (H) Blended families
 - (I) Long term care
 - (J) End of life
 - (K) Grief

Instruction shall include the psychological, psychotherapeutic, community, and health implications of these matters and life events.

- (5) Cultural competency and sensitivity, including a familiarity with the racial, cultural, linguistic, and ethnic backgrounds of persons living in California.
- (6) Human sexuality including the study of physiological-psychological and social-cultural variables associated with sexual identity, sexual behavior and sexual disorders.
- (7) Provide specific instruction in substance abuse and addiction which shall include each of the following areas.
- (A) The definition of alcoholism and other chemical dependency, and evaluation of the affected person.
 - (B) Medical aspects of alcoholism and other chemical dependency.
 - (C) Current theories of the etiology of substance abuse.
 - (D) The role of persons and systems that support or compound the abuse.
 - (E) Major treatment approaches to alcoholism and chemical dependency.
 - (F) Legal aspects of substance abuse.
 - (G) Populations at risk with regard to substance abuse.
 - (H) Community resources offering assessment, treatment and follow-up for the affected person and family.
 - (I) The process of referring affected persons.
 - (J) The prevention of substance abuse.
- (8) California law and professional ethics for marriage and family therapists. This course shall include, but not be limited to, the following areas of study:
- (A) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the profession's scope of practice.
 - (B) The therapeutic, clinical, and practical considerations involved in the legal and

- ethical practice of marriage and family therapy, including family law.
- (C) The current legal patterns and trends in the mental health profession.
- (D) The psychotherapist/patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.
- (E) A recognition and exploration of the relationship between a practitioner's sense of self and human values and his or her professional behavior and ethics.

(9) Psychopharmacology.

(10) No less than six semester or nine quarter units of practicum in a supervised clinical placement that provides supervised fieldwork experience including a minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups. The practicum shall provide training in the following areas:

- (A) applied psychotherapeutic techniques.
- (B) assessment.
- (C) diagnosis.
- (D) prognosis.
- (E) treatment of individuals and premarital, couple, family, and child relationships, including:
 - (1) dysfunctions,
 - (2) healthy functioning,
 - (3) health promotion, and
 - (4) illness prevention.

Educational institutions are encouraged to design the practicum required by this paragraph to include marriage and family therapy experience in low-income and multicultural mental health settings.

(e) A degree qualifying for licensure shall include instruction in the following areas:

- (1) Case management
- (2) Systems of care for the mentally ill
- (3) Professional writing including documentation of services, treatment plans, and progress notes
- (4) Public and private services and supports available for the mentally ill
- (5) Community resources for victims of abuse

The instruction required in this subdivision may be provided either in credit level coursework or through extension programs offered by the degree granting institution.

(f) The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval.

(g) Each applicant shall submit to the board a certification from the educational institution stating that the institution's required curriculum for graduation and any associated coursework completed by the applicant satisfies the requirements of this section.

(h) The changes made to this section are intended to improve the educational qualifications for licensure in order to better prepare future licentiates for practice, and is not intended in any way to expand or restrict the scope of licensure for marriage and family therapists.

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§4980.37. DEGREE PROGRAM; COURSE OF STUDY AND PROFESSIONAL TRAINING

(a) In order to provide an integrated course of study and appropriate professional training, while allowing for innovation and individuality in the education of marriage and family therapists, a degree program which meets the educational qualifications for licensure shall include all of the following:

(1) Provide an integrated course of study that trains students generally in the diagnosis, assessment, prognosis, and treatment of mental disorders.

(2) Prepare students to be familiar with the broad range of matters that may arise within marriage and family relationships.

(3) Train students specifically in the application of marriage and family relationship counseling principles and methods.

(4) Encourage students to develop those personal qualities that are intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.

(5) Teach students a variety of effective psychotherapeutic techniques and modalities that may be utilized to improve, restore, or maintain healthy individual, couple, and family relationships.

(6) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

(7) Prepare students to be familiar with cross-cultural mores and values, including a familiarity with the wide range of racial and ethnic backgrounds common among California's population, including, but not limited to, Blacks, Hispanics, Asians, and Native Americans.

(b) Educational institutions are encouraged to design the practicum required by subdivision (b) of Section 4980.40 to include marriage and family therapy experience in low-income and multicultural mental health settings.

§4980.38. NOTIFICATION TO STUDENTS OF DESIGN OF DEGREE PROGRAM; CERTIFICATION OF FULFILLMENT OF REQUIREMENTS

(a) Each educational institution preparing applicants to qualify for licensure shall notify each of its students by means of its public documents or otherwise in writing that its degree program is designed to meet the requirements of Sections 4980.37 and 4980.40, and shall certify to the board that it has so notified its students.

(b) In addition to all of the other requirements for licensure, each applicant shall submit to the board a certification by the chief academic officer, or his or her designee, of the applicant's educational institution that the applicant has fulfilled the requirements enumerated in Sections 4980.37 and 4980.40, and subdivisions (d) and (e) of Section 4980.41.

(c) An applicant for an intern registration who has completed a program to update his or her degree in accordance with paragraph (1) of subdivision (i) of Section 4980.40 shall furnish to the board certification by the chief academic officer of a school, college, or university accredited by the Western Association of Schools and Colleges, or from a school, college, or university meeting

accreditation standards comparable to those of the Western Association of Schools and Colleges, that the applicant has successfully completed all academic work necessary to comply with the current educational requirements for licensure as a marriage and family therapist.

§4980.39. ADDITIONAL COURSEWORK

(a) Any applicant for licensure as a marriage and family therapist who began graduate study on or after January 1, 2004, shall complete, as a condition of licensure, a minimum of 10 contact hours of coursework in aging and long-term care, which could include, but is not limited to, the biological, social, and psychological aspects of aging.

(b) Coursework taken in fulfillment of other educational requirements for licensure pursuant to this chapter, or in a separate course of study, may, at the discretion of the board, fulfill the requirements of this section.

(c) In order to satisfy the coursework requirement of this section, the applicant shall submit to the board a certification from the chief academic officer of the educational institution from which the applicant graduated stating that the coursework required by this section is included within the institution's required curriculum for graduation, or within the coursework, that was completed by the applicant.

(d) The board shall not issue a license to the applicant until the applicant has met the requirements of this section.

§4980.40. QUALIFICATIONS

To qualify for a license, an applicant shall have all the following qualifications:

(a) Applicants shall possess a doctor's or master's degree in marriage, family, and child counseling, marital and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy, obtained from a school, college, or university accredited by the Western Association of Schools and Colleges, or approved by the Bureau for Private Postsecondary and Vocational Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval. In order to qualify for licensure pursuant to this subdivision, a doctor's or master's degree program shall be a single, integrated program primarily designed to train marriage and family therapists and shall contain no less than 48 semester or 72 quarter units of instruction. The instruction shall include no less than 12 semester units or 18 quarter units of coursework in the areas of marriage, family, and child counseling, and marital and family systems approaches to treatment.

The coursework shall include all of the following areas:

(1) The salient theories of a variety of psychotherapeutic orientations directly related to marriage and family therapy, and marital and family systems approaches to treatment.

(2) Theories of marriage and family therapy and how they can be utilized in order to intervene therapeutically with couples, families, adults, children, and groups.

(3) Developmental issues and life events from infancy to old age and their effect upon individuals, couples, and family relationships. This may include coursework that focuses on specific family life events and the psychological, psychotherapeutic, and health implications that arise within couples and families, including, but not limited to, childbirth, child rearing, childhood,

adolescence, adulthood, marriage, divorce, blended families, stepparenting, and geropsychology.

(4) A variety of approaches to the treatment of children. The board shall, by regulation, set forth the subjects of instruction required in this subdivision.

(b) (1) In addition to the 12 semester or 18 quarter units of coursework specified above, the doctor's or master's degree program shall contain not less than six semester or nine quarter units of supervised practicum in applied psychotherapeutic techniques, assessment, diagnosis, prognosis, and treatment of premarital, couple, family, and child relationships, including dysfunctions, healthy functioning, health promotion, and illness prevention, in a supervised clinical placement that provides supervised fieldwork experience within the scope of practice of a marriage and family therapist.

(2) For applicants who enrolled in a degree program on or after January 1, 1995, the practicum shall include a minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(3) The practicum hours shall be considered as part of the 48 semester or 72 quarter unit requirement.

(c) As an alternative to meeting the qualifications specified in subdivision (a), the board shall accept as equivalent degrees, those master's or doctor's degrees granted by educational institutions whose degree program is approved by the Commission on Accreditation for Marriage and Family Therapy Education.

(d) All applicants shall, in addition, complete the coursework or training specified in Section 4980.41.

(e) All applicants shall be at least 18 years of age.

(f) All applicants shall have at least two years experience that meet the requirements of Section 4980.43.

(g) The applicant shall pass a board administered written or oral examination or both types of examinations, except that an applicant who passed a written examination and who has not taken and passed an oral examination shall instead be required to take and pass a clinical vignette written examination.

(h) The applicant shall not have committed acts or crimes constituting grounds for denial of licensure under Section 480. The board shall not issue a registration or license to any person who has been convicted of a crime in this or another state or in a territory of the United States that involves sexual abuse of children or who is required to register pursuant to Section 290 of the Penal Code or the equivalent in another state or territory.

(i) (1) An applicant applying for intern registration who, prior to December 31, 1987, met the qualifications for registration, but who failed to apply or qualify for intern registration may be granted an intern registration if the applicant meets all of the following criteria:

(A) The applicant possesses a doctor's or master's degree in marriage, family, and child counseling, marital and family therapy, psychology, clinical psychology, counseling psychology, counseling with an emphasis in marriage, family, and child counseling, or social work with an emphasis in clinical social work obtained from a school, college, or university currently conferring that degree that, at the time the degree was conferred, was accredited by the Western Association of Schools and Colleges, and where the degree conferred was, at the time

it was conferred, specifically intended to satisfy the educational requirements for licensure by the Board of Behavioral Sciences.

(B) The applicant's degree and the course content of the instruction underlying that degree have been evaluated by the chief academic officer of a school, college, or university accredited by the Western Association of Schools and Colleges to determine the extent to which the applicant's degree program satisfies the current educational requirements for licensure, and the chief academic officer certifies to the board the amount and type of instruction needed to meet the current requirements.

(C) The applicant completes a plan of instruction that has been approved by the board at a school, college, or university accredited by the Western Association of Schools and Colleges that the chief academic officer of the educational institution has, pursuant to subparagraph (B), certified will meet the current educational requirements when considered in conjunction with the original degree.

(2) A person applying under this subdivision shall be considered a trainee, as that term is defined in Section 4980.03, once he or she is enrolled to complete the additional coursework necessary to meet the current educational requirements for licensure.

(j) An applicant for licensure trained in an educational institution outside the United States shall demonstrate to the satisfaction of the board that he or she possesses a qualifying degree that is equivalent to a degree earned from a school, college, or university accredited by the Western Association of Schools and Colleges, or approved by the Bureau of Private Postsecondary and Vocational Education. These applicants shall provide the board with a comprehensive evaluation of the degree performed by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES), and shall provide any other documentation the board deems necessary.

§4980.41. ELIGIBILITY TO SIT FOR LICENSING EXAMINATIONS; COURSEWORK OR TRAINING

All applicants for licensure shall complete the following coursework or training in order to be eligible to sit for the licensing examinations as specified in subdivision (g) of Section 4980.40:

(a) A two semester or three quarter unit course in California law and professional ethics for marriage and family therapists, which shall include, but not be limited to, the following areas of study:

(1) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the profession's scope of practice.

(2) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including family law.

(3) The current legal patterns and trends in the mental health profession.

(4) The psychotherapist/patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.

(5) A recognition and exploration of the relationship between a practitioner's sense of self and human values and his or her professional behavior and ethics.

This course may be considered as part of the 48 semester or 72 quarter unit requirements contained in Section 4980.40.

(b) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28 and any regulations promulgated thereunder.

(c) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Section 4980.40.

(d) For persons who began graduate study on or after January 1, 1986, a master's or doctor's degree qualifying for licensure shall include specific instruction in alcoholism and other chemical substance dependency as specified by regulation. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Section 4980.40.

(e) For persons who began graduate study during the period commencing on January 1, 1995, and ending on December 31, 2003, a master's or doctor's degree qualifying for licensure shall include coursework in spousal or partner abuse assessment, detection, and intervention. For persons who began graduate study on or after January 1, 2004, a master's or doctor's degree qualifying for licensure shall include a minimum of 15 contact hours of coursework in spousal or partner abuse assessment, detection, and intervention strategies, including knowledge of community resources, cultural factors, and same gender abuse dynamics. Coursework required under this subdivision may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course. The requirement for coursework shall be satisfied by, and the board shall accept in satisfaction of the requirement, a certification from the chief academic officer of the educational institution from which the applicant graduated that the required coursework is included within the institution's required curriculum for graduation.

(f) For persons who began graduate study on or after January 1, 2001, an applicant shall complete a minimum of a two semester or three quarter unit survey course in psychological testing. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it may be considered as part of the 48 semester or 72 quarter unit requirement of Section 4980.40.

(g) For persons who began graduate study on or after January 1, 2001, an applicant shall complete a minimum of a two semester or three quarter unit survey course in psychopharmacology. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it may be considered as part of the 48 semester or 72 quarter unit requirement of Section 4980.40.

(h) The requirements added by subdivisions (f) and (g) are intended to improve the educational qualifications for licensure in order to better prepare future licentiates for practice, and are not intended in any way to expand or restrict the scope of licensure for marriage and family therapists.

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Agenda Item VIII:

Future Meeting Dates

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Memorandum

To: MFT Education Committee

Date: February 27, 2007

From: Paul Riches
Executive Officer

Telephone: (916) 574-7840

Subject: Future Meeting Dates

The committee needs to establish dates for future meetings. At this point, staff believes that we are nearing the end of information gathering and will need to move on to making specific recommendations based on the information collected. As such, staff recommends that the committee establish two additional meeting dates that will focus more strongly on forming specific recommendations to the board. Certainly some new information will be gathered at these meetings (primarily in the form of the occupational analysis results and input from consumers), we suggest targeting final recommendations be formed at the end of the second meeting.

After consulting with the chair the following dates are suggested for future meetings:

Friday, June 15, 2007 [Sacramento]

Friday, September 28, 2007 [TBA]

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